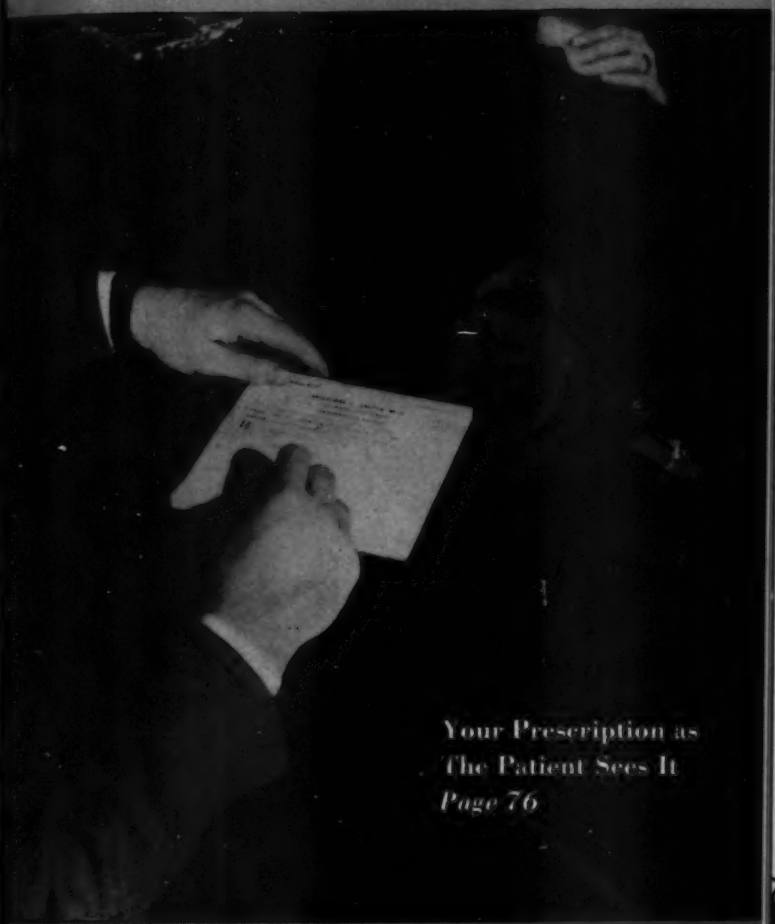
June **Medical Economics**



Your Prescription as
The Patient Sees It
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Medical Economics

* * * *June 1952* * * *

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DEPARTMENTS

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transform discomfort into well-being

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By effectively blocking histamine receptors, Neo-Antergan brings significant symptomatic relief with a minimum of undesirable physiologic effects.

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Your local pharmacy stocks Neo-Antergan Maleate in 25 and 50 mg. coated tablets in bottles of 100, 500, and 1,000.

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Research and Production for the Nation's Health

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* Index of Advertisers *

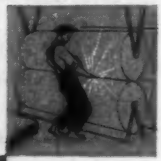
Conducive to normal repair"

Chloresium

Ointment and Solution (Plain)

"Without reservation it may be stated that CHLORESIUM *. . . was soothing, non-toxic, and an active agent in restoring affected tissues to a state conducive to normal repair. . . ."*[1]

A growing volume of published reports confirms the efficacy of CHLORESIUM OINTMENT and SOLUTION (Plain) in the topical therapy of resistant lesions. Here are a few comments from recent investigations:



an extensive crush injury of the hand, provides ". . . an instance of effective healing under CHLORESIUM therapy, following an apparent failure to respond to skin grafting."[1]

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1. Lowry, K. F.: The Management of Resistant, Non-Healing Skin Lesions: A Report of Three Cases, Postgrad. Med., to be published.
2. Niemiro, B. J.: Delayed Healing in Pilonidal Cyst Wounds, Journal Lancet, *71*:364, 1951.
3. Combes, F. C.; Zuckerman, R., and Kern, A. B.: Chlorophyll—Its Use in Topical Therapy, New York State J. Med., to be published.

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Introducing

RED CROSS
ADHESIVE TAPE

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New convenience for busy doctors and nurses

- ★ **The cover does the cutting.**
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Injection
W Y A M I N E® Sulfate
Pressor amine with gentle,
sure and sustained response

Dear Doctor:

When the coronary or surgical hypotensive patient's blood pressure falls, it must be supported. Injection Wyamine Sulfate gives the physician a new, proved aid which will help accomplish this objective.

The pressor response to Wyamine is gentle, sure and sustained, comparable with that of ephedrine in intensity. Wyamine, in contrast to many presently available preparations, including ephedrine, is remarkably free from any undesired side effects. You can inject Wyamine without exposing your patient to the dangers of acceleration of the heart beat and arrhythmia; without fear of causing cerebral stimulation with its attendant restlessness and excitation.

We feel certain you will agree that Wyamine should be in your bag. It is supplied in vials of 1 cc. and 10 cc. (15 mg. Wyamine base per cc.).

MEDICAL DEPARTMENT
Wyeth Incorporated

"therapeutic bile" overcomes stasi

what is "therapeutic bile"?

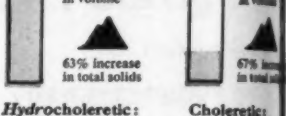
Thin, free-flowing bile in copious amounts as produced by *hydro*choleresis with *Decholin*.

what does "therapeutic bile" do?

Overcomes stasis in chronic cholecystitis and noncalculous cholangitis by flushing thickened bile, mucus plugs and debris from the biliary tract.

how does "therapeutic bile" differ from other bile?

"THERAPEUTIC BILE" is higher fluid content and lower in solid content than bile produced by choleretics, e.g. ox bile salts.



Hydrocholeretic: *Decholin*

Choleretic: Ox bile salts

DECHOLIN®

(brand of dehydrocholic acid)

how is "therapeutic bile" obtained?

"THERAPEUTIC BILE" is obtained by adequate dosage of *Decholin* and *Decholin Sodium*. Most patients require one or two tablets t.i.d. for four to six weeks. Prescription of 100 tablets recommended for maximum efficacy and economy. More prompt and intensive *hydro*choleresis may be achieved by initiating therapy with *Decholin Sodium* 5 cc. to 10 cc. intravenously, once daily.

Decholin Tablets, 3¾ gr. (0.25 Gm.), bottles of 100, 500, 1000 and 5000.

Decholin Sodium (brand of sodium dehydrocholate) 20% aqueous solution, ampuls of 3 cc., 5 cc. and 10 cc.

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D-1

Panorama

Everybody's doing it: Private duty nurses in California have upped their 8-hour fee to $13 for regular care, $15 for special cases . . . The G.P. must avoid overconfidence as well as overwork; or he may, "like the lord of a small domain . . . come to harbor the idea that he can do no wrong," cautions The New England Journal of Medicine . . . After pumping the stomachs of 319 children in a year, Dr. Paul H. Osiek, chief surgeon of the Pasadena, Calif. emergency hospital, reports that the small fry find ant paste more tempting than any other poison. Other favorites: assorted pills, toadstools, paint thinner, moth balls, lighter fluid.

What price euthanasia? Since Dr. Arnold J. Berman confessed the mercy-killing of his brother two years ago, his practice in Eindhoven, Holland, has increased by 30 per cent. His legal punishment: a one-year suspended sentence . . . Around Inverness, Miss., both mansion-dwellers and sharecroppers have chipped in to pay the medical expenses of cancer-ridden, 75-year-old Dr. W. C. Ervin, who rarely sent bills . . . A recent medical program featuring a psychiatrist and a proctologist was billed as "Odds and Ends" . . . About 80 per cent of the drugs used by physicians today were unknown ten years ago, says John C. Krantz Jr., pharmacology professor at the University of Maryland.

Collection note: After Silas Winston of Rocky Mount, N.C., heard Evangelist Billy Graham say "You can't get to heaven owing money," he promptly paid an eighteen-year-old hospital bill for $200 . . . Every physician should be a geriatrician, according to Dr. W. B. Cooksey of Detroit. "The care of the aged," he says, "positively must not be confined to any

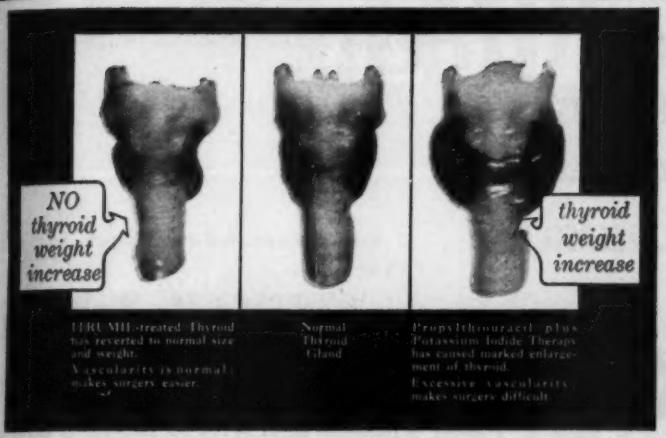
narrow group who have set themselves up as specialists" . . . County P.R. chairmen might take a look at "How to Write and Place a News Release." Published by the New York State medical society, it gives what amounts to a thumbnail course in journalism for doctors.

When death claimed 90-year-old Dr. Samuel T. McKinney of Los Angeles, many school teachers lost a benefactor. Known only as the "Jolly Old Gentleman," he had for years sent them $50 cash Christmas gifts . . . Is it ethical for a physician, as an "associate member" of a group or clinic in another town, to receive fees from it for referred cases? No, says the A.M.A. Judicial Council; "fee splitting under any guise is unethical" . . . French actor Pierre Fresnay will have to play a many-sided role as physician, missionary, philosopher, and Bach expert when he portrays Dr. Albert Schweitzer in a forthcoming film. Part of its proceeds will go to the world-famous doctor's hospital and leper colony in Africa . . . Complaining about high income taxes? So are 71 per cent of your fellow citizens, reports the Gallup poll, which says tax gripes are at an all-time peak.

Plunking down 9,070 pennies to pay for his wife's hospital confinement, Emory Rosburg of Deadwood, S.D., announced that their daughter's name would be Penny Lou . . . Doctors' cars on emergency calls rate a red light or similar warning device, says the Jefferson County (N.Y.) Medical Society, asking its state society to press for such legislation . . . 4-F draft exemptions were sold by an alien physician, Charles Herband, while he was an examining psychiatrist for a Chicago draft board, Federal authorities charge. They're not even sure he's a doctor, they say, since his only credentials are allegedly a 1937 diploma from the University of Louvain, Belgium.

Inflation note: A recent ruling of their ethics committee permits Detroit doctors to increase the lettering on their office signs from three to four inches in height . . . You can't always judge a book by its title: "Medical Ethics and Their Effect Upon the Public," by Louis Guenzel, a Chicago architect, turns out to be

Blocks thyroxin formation without goitrogenic action



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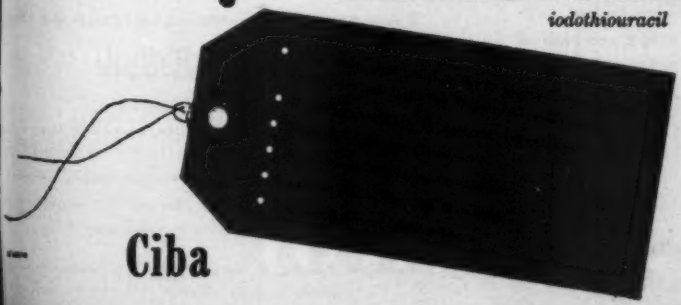

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Literature and samples of Resica, Resinat, Resinat H-M-B and Natrinil available on request.

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THE NATIONAL DRUG CO.
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Penna.

Removes intestinal toxins

RESION

- A palatable suspension of multiple adsorbents
- Effective in diarrhea of infants, children and adults
- Controls the nausea and vomiting of pregnancy
- Effective in bacterial gastrointestinal toxicity
- Valuable adjuvant in the treatment of food poisoning, and gastroenteritis

Available: Bottles of 4 and 12 fluidounces.

8 important advantages for [illegible] therapy—

RESINAT H-M-B

Resinat	0.5 Gm.
Homatropine methylbromide	1 mg.

1. Quick relief of ulcer pain
2. Speeds healing of peptic ulcer
3. Attracts and binds both pepsin and hydrochloric acid
4. Blocks spasm: relaxes the gastrointestinal tract
5. Coats the crater with a protective film
6. Does not cause acid rebound, alkalosis, constipation or diar[illegible]
7. Does not remove chlorides, phosphates, minerals or vi[illegible]
8. Pharmacologically inert

Available: Bottles of 36, 100 and 1,000 tablets.

Removes sodium—controls edem[illegible]

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- To reduce blood pressure in hypertension
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- Controls sodium absorption with minimal dietary restriction[illegible]
- Invites patient cooperation by allowing a more palatable d[illegible]
- Lessens or eliminates the need for diuretics

Available: Powder, 10 ounce bottles and boxes of 24 in[illegible] vidual 10 gram packets.

In G.I. infections—diarrhea—nausea of pregnancy

RESION

In peptic ulcer

RESINAT H-M-B

In hypertension, congestive heart failure and cirrhosis

NATRINIL

a narrative account of the writer's failure to promote a syphilis clinic, a low-cost medical care group, and an M.D. who helped his arthritis. Author Guenzel's conclusion: Socialized medicine can be averted only if doctors are permitted to (1) advertise; (2) reap monetary benefit from their medical discoveries . . . New members of the Indianapolis Medical Society get a free steak dinner and some advice from, respectively, a G.P. and a specialist on how to get along with, respectively, specialists and G.P.'s . . . Uncle Sam to the rescue: When their two local physicians became ill, citizens of Blackstone, Va., asked help from near-by Camp Pickett, and two Army medical officers were assigned to temporary duty as civilian M.D.'s.

Be more civic-minded, the Medical Society of New Jersey urges its members. Big question, it says, isn't "What kind of medicine shall we have to practice in the America of tomorrow?" but "What kind of America shall we have tomorrow to practice medicine in?" . . . Medical equipment, including expensive respirators, will be sent to hard-pressed doctors in non-Soviet Asia by "CARE," the nonprofit relief organization, if it can raise the money in its current drive for funds . . . "Doctors are like politicians—they view with alarm so they can point with pride," philosophizes a character in a new movie, "With a Song in My Heart" . . . More good news for education: Physician-inventors may now take out patents on their medical discoveries, then assign the patent rights to the A.M.A. The latter will distribute the royalties among medical schools.

New York City municipal hospitals recruited 1,026 R.N.'s last year—and lost 1,036 by resignations. In the past ten years there, the number of graduates has fallen from 75 per cent to 28 per cent of the total nursing staff, according to Dr. Marcus D. Kogel, municipal hospital commissioner . . . Since so many non-medical persons (from chiropractors to philosophers) confuse the public by calling themselves "doctor," physicians should abandon the title, says the Montana Medical Association. It suggests that physicians refer to colleagues as "physicians" or "surgeons," and that they use "M.D." on their stationery, prescription blanks, and such.

new convenience

in broad-spectrum therapy

Easily swallowed, sugar-coated Terramycin Tablets introduce new flexibility in prolonged courses of administration and are particularly suited to effective, well tolerated therapy among patients preferring tablets to other oral forms.

Supplied: 250 mg. tablets, bottles of 16 and 100; 100 mg. and 50 mg. tablets, bottles of 25 and 100.

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tablets
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COMBIOTIC
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Finer Fruits And Vegetables Make Heinz Baby Foods First Choice For Flavor!

Only Fruits And Vegetables From America's Finest Farmlands Are Rich Enough In Flavor, Vitamins And Minerals For *Heinz* Baby Foods. That's Why—When You Recommend Heinz—You Can Be Sure Babies In Your Care Get The *Maximum* In Health Building Elements And Appetite-Tempting Flavor.

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2. Heinz Baby Foods are scientifically cooked for higher nutritive value—finer flavor, color and texture!

3. Heinz quality is laboratory controlled for absolute uniformity.

4. Better-tasting Heinz Baby Foods are backed by the 83-year-old 57 symbol of quality.

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OVER 50 VARIETIES: STRAINED FOODS . . . JUNIOR FOODS . . . PRE-COOKED CEREAL FOOD . . . PRE-COOKED OATMEAL CEREAL . . . PRE-COOKED BARLEY CEREAL

Can You Afford Not to Use SEAMLESS *"Kolor-Sized" Latex Surgeons Gloves*

Seamless "Kolor-Sized" Latex Gloves Invite Inspection on Every Measurement of Glove Quality

IN ADDITION – Seamless "Kolor-Sized" Latex Gloves Offer an Exclusive Combination Feature AT NO EXTRA COST

1. "Kolor-Sized"®
2. Banded

Wrist Band Color Code:
Blue — Size 6½ Black — Size 7½
Gray — Size 7 Green — Size 8
Yellow — Other Sizes

What this Means to You in Longer Glove Life, Saved "Nurse-Hours"

● Seamless banding gives these latex gloves *extra* strength. Beading serves to further reinforce glove at vital "pull on" point. That means fewer tears, longer life. That means dollar economy! Doctors like banding because it keeps gloves up, prevents "roll down."

And, listen to what hospitals say about "Kolor-sizing". . . "it requires just half the time it formerly took to test and put up surgeons gloves". . . "no size confusion". . . "we have put the 'found' hours to good use" . . . That means nurse economy! *"Simply sort by color and you sort by size.'*

SPECIFY SEAMLESS "KOLOR-SIZED" BROWN OR WHITE LATEX SURGEONS GLOVES FOR GUARANTEED SATISFACTION

● Remember, there are no finer Latex gloves offered today than Seamless Brown and White Latex surgeons gloves, AND they are both banded and "Kolor-Sized" for economy and convenience. For early delivery, order your requirements in all sizes through your Surgical Supply Dealer. (Also Seamless "Kolor-Sized" Brown Milled Surgeons Gloves.)

1877 75th 1952

The New Short-Term Therapy in Acute Allergies

The therapeutic results of short-term therapy with ACTHAR *Gel* in acute bronchial asthma and hypersensitivity states are vastly superior to conventional methods of treatment in the majority of cases.

ACTHAR *Gel* (in Gelatin)—the new repository ACTH preparation—brings about rapid and prolonged relief; marked subjective and objective improvement is noted within hours, and complete remissions have been observed within 2 days. Metabolic side-effects are virtually absent due to the short period of therapy required. Fewer injections are required with ACTHAR *Gel*, since an individual dose lasts for as long as 12 to 16 hours.

Office treatment for the ambulatory patient and home treatment for the bedridden are simple, convenient and economical.

ACTHAR *Gel*

The Armour Laboratories Brand of Adrenocorticotropic Hormone ACTH (Corticotropin)

rapid response
prolonged action

ACTHAR *Gel* (in Gelatin) is available in 5 cc. multiple dose vials in 20 and 40 U.S.P. units (I.U.) per cc.

ACTHAR *Gel* (in Gelatin) is also available in sterile 1 cc. B-D† Disposable Cartridge Syringes in 20 and 40 U.S.P. units (I.U.) per cc.

†T.M. Reg. Becton, Dickinson & Co.

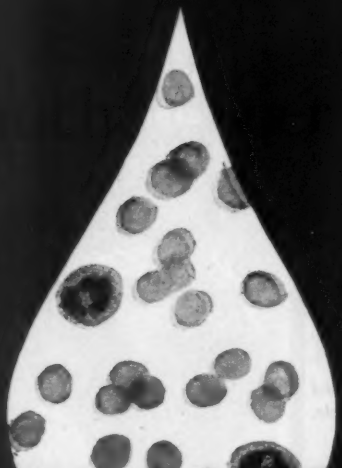
Announcing

HP* ACTHAR *Gel*—the first Highly Purified repository ACTH preparation—for practical subcutaneous injection. Low-protein, low-solid characteristics assure minimum discomfort on administration. Supplied in 20 and 40 Armour Units per cc. in 5 cc. vials and 1 cc. B-D† Disposable Cartridge Syringe.

**Highly Purified*

THE ARMOUR LABORATORIES
CHICAGO 11, ILLINOIS
-world-wide dependability-

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH



Zymatinic Drops

Upjohn

Speaking Frankly

Too Many Meetings!

SIRS: Your cartoon depicting the flood of medical meetings that inundate the profession produced considerable comment among my colleagues. Like all other communities, we face the same problem.

In our city of 12,000, we have two hospitals, both approved by the American College of Surgeons. The same group of M.D.'s comprises the staff of each; so the same faces turn up at *two* staff meetings each month.

It has occurred to us that it might be better to combine these. Wouldn't we get more out of one good meeting per month than out of two meetings that regularly feature the same old stuff? Study groups, clinic groups, county society meetings, and other gatherings take up so many of our evenings that it is difficult to find time for our families or for worthwhile non-medical community activities.

Does anyone know of instances in which staff meetings have been successfully combined? We would welcome any opinions or suggestions.

Clyde O. Merideth, M.D.
Emporia, Kan.

Many county medical societies—for example, those in Omaha and Detroit—have already tackled the multiple-meeting problem. For news of recent developments, see page 225 of the May, 1952, MEDICAL ECONOMICS.

'Oh, To Be in England . . .'

SIRS: A recent news item in MEDICAL ECONOMICS reports that the earnings of the average British G.P. are about $5,000 a year. [For a later report, see page 211, this issue.] I spent a month in England last summer, and this coincides with my information. But in headlining your item "British Doctors Barely Keeping Wolf at Bay," you have arrived at the wrong conclusion.

Although it's true that they can't get all the steak they want, British doctors are not starving under the National Health Service. The $5,000 they get will buy almost 100 per cent more in England than would an equivalent sum in this country.

British medical men drive good cars, and they can get them. They live in nice homes; and if they go away for a P.G. course or a vacation, they are certain to find their practices intact when they return. To top it all, they are not cheated out of fees, since they don't have to send bills and employ collection agencies.

The British public at large is very

happy with the National Health Service, and nobody will dare touch it.

Eugene F. Kalman, M.D.
Bridgeport, Conn.

Wants Caduceus Back

SIRS: Your Panorama item saying that Air Force medical officers have been "shorn" of their medical insignia when off duty is only too true. The reason given for the new regulation is, as you put it, that it spares doctors "from free-loading advice seekers."

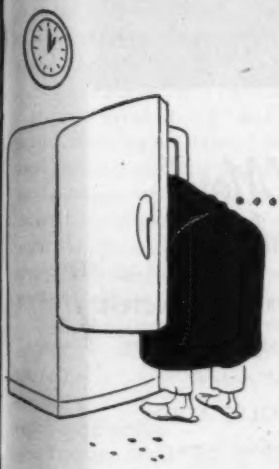
If the men at this base are representative, I think you'll find that Air Force medical officers as a whole are much against this shearing. Doctors in other banches of the armed forces are properly identified, and we think we deserve the same right. As it stands, there is no recognition of the fact that we have had eight to twelve years of intensive medical education.

As for the advice seekers, the problem is the same with or without insignia. Even though we travel incognito, it doesn't take long for a doctor to get known. Besides, we find that most people are considerate; only a very few choose the wrong time to seek consultation.

M.D., Washington

Hasn't Spoken Up

SIRS: Your article on the President's Commission on the Health Needs of the Nation [March MEDICAL ECONOMICS] presents the matter, for the most part, with great fairness. On page 187, however, you identify me, along with three others, as a commission member who has "in the



....control CHEATERS!

"Patients who have been gaining excessively but are on reduced caloric intakes, will tell you that they are not eating excessively; that there is something wrong with them because they gain weight. Obviously they are cheating, consciously or unconsciously. One cannot gain weight on air and water."[1]

AMPLUS helps control the obese patient's urge to cheat. The appetite-curbing effect of dextro-Amphetamine Sulfate, plus the nutritional supplementation of 8 Vitamins, 11 Minerals, and Trace Elements increases patient co-operation, and guards against nutritional deficiencies frequently encountered in obese patients.

1. Dieckmann, W. J.; Turner, D. F.; Meiller, E. J.; Straube, M. T.; Groesnickle, K. B.; Pottinger, R. E.; Hill, A. J.; Savage, L. J.; Forman, J. B.; Priddle, H. D.; Beckette, E. S.; Schumacher, E. M.: Diet Studies in Pregnant Patients. Obst. & Gynec. Surv. 3:731 (Oct.) 1948, p. 742.

To help cheaters to self-control, prescribe...

AM PLUS

ETHICAL Roerig Rx PHARMACEUTICALS

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536 N. Lake Shore Drive • Chicago 11, Ill.

Each capsule contains:

DEXTRO-AMPHETAMINE SULFATE...	5 mg.
Calcium	242 mg.
Cobalt	0.1 mg.
Copper	1 mg.
Iodine	0.15 mg.
Iron	3.33 mg.
Manganese	0.33 mg.
Molybdenum	0.2 mg.
Magnesium	2 mg.
Phosphorus	187 mg.
Potassium	1.7 mg.
Zinc	0.4 mg.
Vitamin A	5,000 U.S.P. Units
Vitamin D	400 U.S.P. Units
Thiamine Hydrochloride	2 mg.
Riboflavin	2 mg.
Pyridoxine Hydrochloride	0.5 mg.
Niacinamide	20 mg.
Ascorbic Acid	37.5 mg.
Calcium Pantothenate	3 mg.

Available at all Pharmacies

...not spoken up for the Ewing plan." On page 188 you indicate that I am also inclined toward Federal subsidies.

So far as I am aware, I have never personally "spoken up" for the Ewing plan nor for subsidies. I should not like to have any false impression given to your very large reading audience about my views, particularly since all members of the commission, including myself, are making a most sincere attempt to act in an impartial, unprejudiced fashion.

Dean A. Clark, M.D.
Boston, Mass.

Our Lay Public

SIRS: For the third time in recent years, you have advised doctors not to put MEDICAL ECONOMICS in the waiting room for patients to see. Why is it, then, that MEDICAL ECONOMICS is still available for lay people to read in hospitals and clinics?

M.D., Maine

With rare exceptions, MEDICAL ECONOMICS *reaches physicians in private practice only. It's not generally available to lay readers* except *when physicians themselves make it so.*

Old Doctors Never Die

SIRS: In a recent issue of MEDICAL ECONOMICS there appeared a reference to the overworked and understaffed medical department of the Armed Forces. This so-called shortage used to worry me, but as a result of my own experience with Army recruiting, I wonder whether I *should* worry.

Within the past three years, I have offered my services to the medical departments of the Army and the Air Force. Twice, I have had a complete medical and physical examination and both times have been certified as fit for active duty. In each case, after an interval of several weeks, I was thanked for my patriotism and commended therefor. *But* since I was past my fifty-fifth birthday, I could not be granted an initial commission.

My contention is that if a physician over 55 is able to pass the physical examination, he could be of greater service in base hospitals and induction centers than many younger men. Hundreds of medical men are being kept out of the armed services because of this outmoded regulation.

George E. Mueller, M.D.
Biloxi, Miss.

Better in Brooklyn?

SIRS: In a recent Newsvane item, you quote the Pittsburgh Post-Gazette as saying that increased competition in the larger cities would cause more doctors to settle in outlying areas. Most doctors will disagree with this opinion.

The average practitioner in, say, Brooklyn, N.Y., would prefer to make $8,000 a year there than $16,000 in West Bulrush. The reasons are mainly social and profes-

Through the Menstrual Years of Life . . .

THE frequency with which the menstrual life of so many women is marred by functional aberrations that pass the borderline of physiologic limits, emphasizes the importance of an effective uterine tonic and regulator in the practicing physician's armamentarium.

In ERGOAPIOL (Smith) with SAVIN the action of all the alkaloids of ergot (prepared by hydro-alcoholic extraction) is synergistically enhanced by the presence of apiol and oil of savin. Its sustained tonic action on the uterus provides welcome relief by helping to induce local hyperemia, stimulating smooth, rhythmic uterine contractions and serving as a potent hemostatic agent to control excessive bleeding.

May we send you a copy of the booklet "Menstrual Disorders", available with our compliments to physicians on request.

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The Preferred Uterine Tonic

Obocell®

doubles the power to resist food in obesity

Both obstacles to reducing are overcome by OBOCELL: (1) Obocell suppresses bulk hunger and creates a sense of fullness and satisfaction; (2) Obocell curbs the appetite and elevates the mood. Now available—Obocell Liquid for patients who prefer liquid medication.

IRWIN, NEISLER & CO., Decatur, Ill.

...nal. There's an old saying: "Better a year in Rome than a cycle in Cathay."

Lyon Steine, M.D.
Valley Stream, N.Y.

Pre-Employment Exams

SIRS: I read with interest the story of "Raymond Seth's Other Practice" [February, 1952]. Please, if such ventures are to be described, let us not besmirch the name of industrial medicine by noting them as an "accomplishment in the realm of industrial medicine."

Such pre-employment examinations may be a type of medical activity still associated with some industries, but they in no way represent the philosophy, practices, or objectives of the specialized field of industrial medicine. Industry and industrial medicine are poorly served by labeling such obsolete, ineffective, and inaccurate concepts "industrial medicine."

Fifty thousand dollars per year [the cost of the Seth program] would go a long way toward providing a seasonal industry of 9,000 workers with a positive and comprehensive program of health maintenance and conservation—*including* pre-placement examinations.

Ronald F. Buchan, M.D.
N.Y.U.-Bellevue Postgraduate Medical School
New York, N.Y.

Free-Care Costs

SIRS: Your article "Private Care for Public Patients" [April, 1952] gives

a good picture of the Indiana [illegible] gent-care project. The A.M.A. Committee on the Care of the Indigent, of which I am a member, is currently analyzing a number of such programs throughout the country.

The Indiana program looks and sounds ideal, but we are having difficulty in ascertaining the cost of the plans. It would seem to me that this is a very costly one. Since the books are not available to us for study, however, it is not possible to determine whether it really is exorbitant.

Joseph H. Howard, M.D.
Bridgeport, Conn.

Rural Reflections

SIRS: As a G.P. who has practiced for thirty years in a town of under 5,000, I well understand the situation outlined in "More Doctors for Rural Areas" [January, 1952].

In my opinion, the reluctance of young M.D.'s to settle in small towns is caused largely by the spread of Blue Cross, Blue Shield, and similar plans designed by the city boys to funnel all patients into their hospitals. Because these plans make no provision for home and office treatment, they fill the hospitals with the rural physician's patients—thus making a mere first-aider out of him. This alone is enough to dishearten any ambitious young doctor who would like to locate in the country.

City doctors today treat the rural physician like a stepchild. The situation was certainly different when I started out in practice. In those days, the rural M.D. was accepted as one of the profession. The old-

nox Gelatine . . . useful protein supplement

the growing child

For Body Growth

Protein not only helps feed the machine
he growing child but is itself the machin-
. An abundance of protein both for body
owth as well as for blood, enzyme and hor-
ne synthesis is a primary requirement in
ildhood. While carbohydrate and fat may
stored in the organism, protein must be
en in daily to maintain the structural mass
issue.

Abundant Energy

The daily diet must contain the so-called
ential amino acids as first shown by Os-
ne and Mendel[1] and more precisely de-
d by Rose.[2] Once the essential amino
ds are furnished, the remaining ones may
aken in abundance from other protein
rces to insure full growth and create
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betes, Colitis, Peptic Ulcer . . . Low
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Easy to Digest

Knox Gelatine is an excellent protein supplement, easy to digest and administer, and non-allergenic. It may be prepared in a variety of ways from Knox Gelatine Drink to delicious salads and desserts.

High Dynamic Action

Gelatine in the form of gelatinized milk has been found a valuable protein supplement helpful in allergies, celiac disease, colic and to increase the digestibility of the milk formula.[3] Its high specific dynamic action[4] which spares essential amino acids and furnishes amino acids for the continuous dynamic exchange of nitrogen in the tissue[5] helps the child to maintain the normal body heat. Furthermore, it contains an abundance of important glycine and proline necessary for hemoglobin formation.

1 Osborne, T.B. and Mendel, L.B., J. Biol. Chem. 17:325, 1914.
2 Rose, W.C., Physiol. Rev. 18:109, 1938.
3 Wolpe, Leon Z. and Silverstone, Paul C., J. Pediat. 21:635, 1942.
4 Lusk, G., J. Nutrition 3:519, 1931. Borsook, H., Biol. Rev. 11:147, 1936.
5 Schoenheimer, R., Rittner, S., and Rittenberg, D., J. Biol. Chem., 127:333, 1939 and 130:703, 1939.

Available at grocery stores in 4-envelope family size and 32-envelope economy size packages.

KNOX GELATINE U. S. P.

All Protein No Sugar

time internist, after seeing a referred patient, phoned his report to the referring physician; and the surgeon invited him to be present at the operation. Chances are, the rural doctor was also invited by such specialists to the theatre or to a ball game once or twice a year.

What happens today? The country physician is scarcely trusted to change the postoperative dressings of a patient he has referred. And the surgeon shows his appreciation (*if* he remembers) by having his secretary send him a Christmas card.

All of this, besides galling established men like myself, is certainly not conducive to attracting young physicians to the country. Under the present set-up, they can expect to act only as referral depots. Their patients reserve the right to disregard office hours and expect miracles—failing which they dash off to a so-called specialist in the city at twice the fee.

M.D., Missou

Laughter

SIRS: Both my secretary and I have enjoyed your cartoons so much that we thought it only fair to share our amusement. Now, laughter can be heard throughout my daily office hours. Why? A scrapbook of MEDICAL ECONOMICS cartoons reposes on the waiting room table for all to see.

J. Wiley Hartman, M.D.
Latrobe, Pa.

Our thanks are extended, but our fingers are crossed.

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in the treatment of allergies and dermatoses

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(BACTERIAL POLYSACCHARIDE)

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Pyromen **is proving to be increasingly useful in the treatment of many allergies and dermatoses, as well as certain ophthalmic disorders.**

Pyromen **is supplied in 10 cc. vials containing 4 gamma (micrograms) per cc. and in 10 cc. vials containing 10 gamma per cc.**

"*Pyromen*" on your *Rx* will bring you our new booklet detailing the use of this new therapeutic agent.

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Arobon®

meets the patient's first demand

In diarrheas, Arobon assures rapid control of the abdominal distress, the frequent stools, and the resulting generalized discomfort.

Processed from specially prepared carob flour, Arobon contains a high proportion (22 per cent) of pectin, lignin, and hemicellulose. Its adsorptive and demulcent actions serve to remove offending bacteria and toxins, and the gelatinous mass it forms on taking up water soothes the inflamed bowel.

Arobon produces excellent results in the nonspecific diarrheas of adults, children, and infants, often leading to formed stools in 12 to 15 hours. In the specific dysenteries, its action is valuable in conjunction with indicated chemotherapeutic agents.

SIMPLE TO PREPARE AND HIGHLY PALATABLE

For adults and children, Arobon is simply prepared by stirring the powder into milk. Average dose for adults, two level tablespoonfuls in four ounces; for children, one level tablespoonful in four ounces.

For infants, two level teaspoonfuls in four ounces of skim milk or water and boiled for ½ minute.

When mixed with milk, Arobon forms a pleasant chocolate-like drink.

Available in five ounce bottles through all pharmacies

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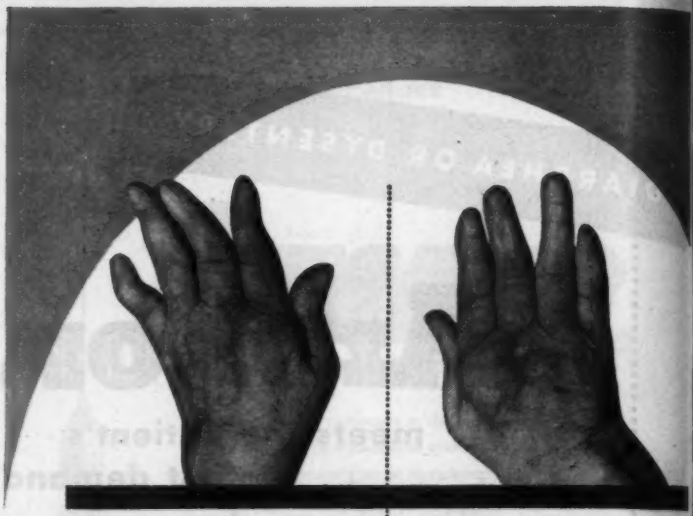

—For 17 Years—

Thousands of physicians have been using ERTRON—Steroid Complex, Whittier, with good results in the treatment of arthritis.

The very high percentage of relief observed by the fifty-two investigators reporting to date is a matter of record.

ERTRON produces sustained relief and objective improvement, often maintained after cessation of therapy. There are no "withdrawal symptoms."

ERTRON used by the physician affords a minimum of reaction.

There is no observed interference with adrenal activity.

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LABORATORIES
Chicago 11, Illinois

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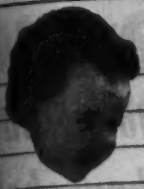

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infant dermatoses

protective — Desitin Ointment "showed definite prophylactic properties" with the incidence of nonsuppurative dermatoses about one-third that of control group.

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in **diaper rash**
- **exanthema**
- **non-specific dermatoses**
- **intertrigo** • **chafing**
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(due to urine, excrement, chemicals or friction)

Desitin Ointment is a non-irritant blend of high grade, crude Norwegian cod liver oil (with its unsaturated fatty acids and high potency vitamins A and D in proper ratio for maximum efficacy), zinc oxide, talcum, petrolatum, and lanolin. Does not liquefy at body temperature and is not decomposed or washed away by secretions, exudate, urine or excrements. Dressings easily applied and painlessly removed.

Issued 1 oz., 2 oz., 4 oz., and 1 lb. jars.

write for **samples** and reprints

DESITIN CHEMICAL COMPANY •
Ship Street • Providence 2, R. I.

1. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediat. 68:382, 1951.
2. Behrman, H. T., Combes, F. C., Bobroff, A. and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.

When the problem is *more than household chores...*

. . . only 3 IBEROL tablets a day will provide the therapeutic dose needed to control iron-deficiency anemia.

For effective hemoglobin regeneration, IBEROL therapy offers an easy-to-swallow tablet with a potent source of iron (210 mg.). In addition, IBEROL contains generous amounts of vitamin B_{12}, folic acid and other B complex factors as well as standardized stomach-liver digest and ascorbic acid.

IBEROL potency and compactness are the result of an ingenious pharmaceutical technique which utilizes the iron content itself as one of three coatings to protect the vitamins. An outer sugar-coating masks the iron, gives the tablet a pleasant odor and taste.

For prophylaxis in old age, convalescence or pregnancy, one or two IBEROL tablets a day are usually enough. IBEROL may be used for the supplemental treatment of pernicious anemia. Available in bottles of 100, 500, 1000.

Abbott

THREE IBEROL TABLETS:

the average daily therapeutic dose for adults, supply:

Ferrous Sulfate	1.05 Gm.
(representing 210 mg. elemental iron, the active ingredient for the increase of hemoglobin in the treatment of iron deficiency anemia)	
Plus these nutritional constituents:	
Vitamin B_{12}	30 mcg.
Folic Acid	3.6 mg.
Stomach-Liver Digest	1.5 Gm.
Thiamine Mononitrate (6 times MDR*)	6 mg.
Riboflavin (3 times MDR*)	6 mg.
Nicotinamide (2 times RDA†)	30 mg.
Pyridoxine Hydrochloride	3 mg.
Pantothenic Acid	6 mg.
Ascorbic Acid (5 times MDR*)	150 mg.

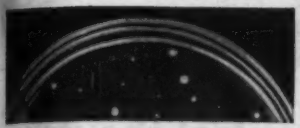
*MDR—Minimum Daily Requirement
†RDA—Recommended Daily Dietary Allowance

Iberol

(Iron, B_{12}, Folic Acid, Stomach-Liver Digest, with Other Vitamins, Min

DIAL SOAP with Hexachlorophene effects 95% reduction in skin bacteria

Photomicrographs show why



With ordinary soap. Even after thorough washing, thousands of active bacteria remain on the skin.

With Dial soap. Daily use of Dial with Hexachlorophene eliminates up to 95% of resident skin bacteria.

1. *Reduces chance of infection* following skin abrasions and scratches because Dial effectively reduces skin bacteria count.

2. *Stops perspiratory odor* by preventing bacterial decomposition of perspiration, known to be the chief cause of odor.

3. *Protects infants' skin,* helps prevent impetigo, diaper and heat rash, raw buttocks; stops nursery odor of diapers, rubber pants.

4. *Helps skin disorders* by destroying bacteria that often spread and aggravate pimples, surface blemishes.

You know, of course, the remarkable antiseptic qualities of Hexachlorophene soaps, as documented in recent literature. Dial was the first toilet soap to offer Hexachlorophene content to the public. You can safely recommend Dial. Under normal conditions it is non-toxic, non-irritating, non-sensitizing. Furthermore, Dial Soap is economical, and widely available to patients everywhere.

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contact dermatitis
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Bristamin* Lotion affords prompt and sustained relief from itching, allergic or non-allergic in origin, with three or four applications daily.

A new, versatile antihistaminic and antipruritic, it is supplied in a cosmetically delightful neutral base which fastidious patients will appreciate.

Contains no calamine, phenol, or other drying ingredients to cause intensified rebound symptoms.

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*Bristamin brand of Phenyltoloxamine, an exclusive development of Bristol research, is an antihistaminic, antimycotic, and topical anesthetic with an exceptionally low order of toxicity.

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RUTOL*

IS THE LOGICAL FORMULA

EACH TABLET CONTAINS:

Mannitol hexanitrate	16 mg.(1)
Rutin	10 mg.
Phenobarbital	8 mg.

(1) This specially-designed formula permits dependable nitrite therapy with less risk of developing nitrite *tolerance*.

Rutol is particularly favored by physicians advocating "interrupted" nitrite therapy—to maintain *maximal* therapeutic response. The 16 mg. (¼ gr.) of mannitol hexanitrate in Rutol Tablets provides the established *minimal effective dose*—together with a prophylactic dosage of rutin, to guard against vascular accidents, and phenobarbital, for cerebral sedation.

PITMAN-MOORE COMPANY

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*TRADE MARK

Sidelights

Telephone Test

Have you checked up on your telephone-answering service lately?

Several doctors we know, while away from their offices, have been placing occasional test calls. In a disturbing percentage of these cases, we're told, the answering service has responded brusquely, or garbled the message, or failed to get names and numbers right. In one instance, all the operator would say was: "No, I don't know where the doctor can be reached. Call back later."

Obviously, this is more than a waste of money; it's a sharp blow to the doctor's reputation with his patients. Better look into it in your own case.

Political Straw

A bunch of Californians have been conducting something they call "grass-roots polls" in an effort to determine which American, if made the Republican nominee for President, would have the greatest vote appeal. What caught our eye was their recent finding that two physicians rated among the top twelve.

One was Dr. George W. Crane, the widely read health columnist and business psychologist, who placed seventh in the straw balloting—being topped only by the Republican big six (Warren, Eisenhower, Taft, MacArthur, Stassen, and Dewey, in that order). An enthusiastic backer characterized Dr. Crane as "a second Lincoln—the only man whose integrity we could be sure of."

Almost equally fervent was the support generated for Dr. Walter H. Judd, the Congressman from Minnesota, who placed twelfth. A former medical missionary in China, Judd has been a consistent critic of the present Administration's Far East policy.

These poll results, we can safely predict, will have absolutely no effect on the nominating convention next month. But they do symbolize the political progress that physicians have made in the last few years. By 1956 . . . who knows?

Combined Billing

Two private physicians work together on a case. Later, they send the patient a single bill, itemizing the amounts owed to each physician.

Anything wrong with that?

It all depends on where you turn for the answer. The Iowa State Medical Society, for example, maintains

that joint billing is both custo
and ethical. The American Co
of Surgeons, on the other h
maintains that it isn't—that it's
likely to become a screen fo
splitting. The American Medical
sociation has taken no clear stand
the issue, although its Judicial Co
cil reportedly advises against
bined bills.

There's something to be sa
both sides of this controversy.
fortunately, most of it is being
sub rosa—and, in some cases,
considerable bitterness.

We think the A.M.A., at its
sion this month, could be of tremen
dous service to doctors everywhe
by bringing up the subject for o
discussion, by letting both speci
ists and G.P.'s have their say,
then by specifying not only what
best policy seems to be, but *why*.

British Yardstick

Has the National Health Serv
made any difference in British m
tality rates?

As far as the record shows, t
state medical scheme has not y
brought about any major chang
The minor changes, however, a
causing some concern—as witne
the following Parliamentary e
change, reported recently by th
British Medical Journal:

"Sir Herbert Williams asked o
January 31 what steps the Ministe
of Health proposed to take to restor
the medical service to the peopl
to the standard of efficiency which
prevailed prior to July 1, 1948, i

view of the heavy increase in mortality in the first three years of the service as compared with the three previous years.

"Miss Pat Hornsby Smith replied [for the Health Ministry] that after allowing for relevant factors . . . the difference in mortality was extremely small, and Mr. Crookshank [the Health Minister] was unable to accept the implication in the question."

Which suggests that the true effect of socialized medicine on British health should be measured as soon as possible—for our guidance as much as for theirs. Meanwhile, the mortality results are presumed to be neither black nor white, but a rather ominous gray.

What! No Politics?

Two distinguishing features of any A.M.A. House of Delegates session are profuse hospitality and diffuse politicking. The combination will no doubt pleasantly permeate this month's Chicago session, just as it did last December's meeting in Los Angeles. A tale from the latter affair may illustrate the nature of the blend:

Doctors from Washington State, it seems, had never done much entertaining at previous A.M.A. sessions. This time they decided to go all out.

So they rented a suite in an L.A. hotel and stocked it with such Washington State delicacies as smoked oysters, Wenatchee apples, and Anjou pears. As the pièce de résistance, they arranged to have a huge King

"It was just the help I needed —when you took me off coffee!"

It isn't always easy for patients to follow your orders—when you advise giving up coffee. But, as you know from experience, you'll get more cooperation from your patients if you suggest *caffein-free* Postum instead. They'll like its hearty flavor—find it easier to *stay off* coffee! So, to help *you* help your patients, we'll be happy to send you, without charge or obligation, our Professional Pack of 12 trial-size packages of Instant Postum. Use the handy order blank below.

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While many people can drink coffee or tea without ill effect—for others, even one to two cups may result in indigestion, hypertension and sleepless nights. *See "Caffein and Peptic Ulcer" by Drs. J. A. Roth, A. C. Ivy, and A. J. Atkinson —A. M. A. Journal, Nov. 25, 1944.*

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Please send me, at no cost or obligation, your Professional Pack of 12 trial-size jars of Instant Postum.

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Street.....

City..... *State*.....

Offer expires August 1, 1952. Good only in Continental U.S.A.

salmon flown in daily from Seattle and baked whole. All this for the gormandizing of visiting M.D.'s.

Every day the Washington State played host. Their "open house" appeared to be an unqualified success —until you listened to one of the hosts:

"I just can't understand it," this doctor said. "Naturally, we're pleased to have so many visitors come in and see us—if for no other reason than to show them what our home state has to offer. But what happens? Ninety-five per cent of our visitors take me aside to ask me what, or whom, we're campaigning for.

"What's the matter with these people? Must there always be an 'angle'? Haven't they ever heard of just plain Western hospitality?"

Poolroom Practice

Seen in the emergency ward: A strapping colored boy with a billiard ball bulging from his mouth.

Despite the hands gesturing frantically for help and the eyes rolling white with terror, the net effect was fantastically comic. Between the two arcs of milk-white teeth shone the wedged-in black ball, with the figure eight foremost.

It took deep anesthesia and the extraction of two incisors to remove the boy from behind the eight-ball. There was a happy ending, though. For by the terms of his bet, he'd been required only to get the ball *into* his mouth. The net gain of the transaction was four bits.

CONSTIPATION*

possibly the

greatest single medical problem

of the patient who is over **40**

In these cases, laxation alone isn't enough.

Because constipation in this age group is usually associated with indigestion and biliary stasis. Prescribe Caroid® and Bile Salts with Phenolphthalein to obtain these three beneficial actions:

choleretic action — for an increased flow of bile

digestant action — aids protein and fat digestion

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Supplied — bottles of 20, 50, 100, 500 and 1000 tablets

write for professional samples to

AMERICAN FERMENT CO., Inc. 1450 Broadway, New York 18, N. Y.

*Rehfuss, M. E.: Indigestion, Philadelphia, W. B. Saunders Co., 1943, p. 322

CAROID® AND BILE SALTS *tablets*

Specifically indicated in ***biliary dyspepsia and constipation***

Check list for JOHNSON'S BABY LOTION

- ☑ Backed by extensive clinical studies on animal and human subjects...
- ☑ Effective against a wide variety of potential pathogens commonly found on the infant's skin...
- ☑ Manifests a gratifyingly low incidence of sensitization...
- ☑ Of proved value in the prophylaxis and therapy of *miliaria*, *excoriated buttocks*, *diaper rash*, *impetigo*, and *cradle cap*...
- ☑ Smooth-textured, readily vanishing and pleasantly fragrant...
- ☑ Excellent for general cleansing and lubrication of the skin, whether applied to the perineal region only, or to the entire body...

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For Sacroiliac Sprain, a narrow belt alone is not enough . . .

That is why Spencer Designers incorporate an easily-adjustable pelvic binder (see inset above) inside each Spencer created for sacroiliac sprain.

A narrow belt alone will not provide adequate continuous immobilization of the sacroiliac joints because such a belt will not stay in place. With ordinary body movements, any narrow belt alone will ride-up and dig-in at the back, thus causing faulty posture that increases the disability. That is why every Spencer Sacroiliac Support is a "belt within a support"—designed to the necessary heights and lengths to bridge the lumbar curve and correlate abdominal and back support. Thus improvement in posture—essential to relief in sacroiliac sprain—is attained and maintained.

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Canada: Spencer, Ltd., Rock Island, Que.
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Send FREE booklet, "Spencer Supports in Modern Therapy."

Name ..... M.D.

Address .....

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SPENCER

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The pain and discomfort of sinusitis can be quickly and effectively relieved, without relying on narcotics, by using an analgesic like Anacin. The advantage of the APC formula, as provided by Anacin, is the fast-acting and prolonged relief that is so gratifying to the patient. And Anacin may be taken *safely* over long periods of time where continued use is indicated with no undesirable side effects. Anacin is available at all pharmacies for the convenience of your patients. Samples will be sent on request.

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a friend of the enema..

Sometimes this type will admit taking a 2-quart enema ev
week or even more frequently.

Aside from the inconvenience, it provides only tempor
relief and is actually irritating.

Here is where Turicum can be a big help in establishing no
mal function.

It is not a one-dose laxative but a treatment that, taken f
a few days, helps restore normal function.

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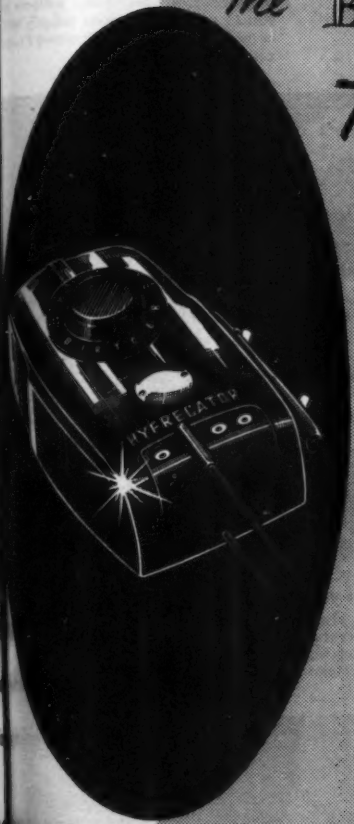
A DIVISION OF NUTRITION RESEARCH LABORATORIES, IN

The BIRTCHER Hyfrecator



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Since 1939, when the Birtcher Hyfrecator was first introduced to the Medical Profession, over 70,000 doctors have purchased the device. A great number of unsolicited testimonials have been received praising its broad usefulness, its convenience and its simplicity.

Such widespread acceptance and approval make a convincing demonstration of the proven worth of the Hyfrecator in practically every type of practise. If you do not own one, now is the time to investigate how a Hyfrecator may be of value in your office. It is inexpensive; it is probably the best dollar value one can find today. Complete descriptive literature of the instrument and its uses is yours for the asking.

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Making special diets "something special"

To encourage special-diet patients to follow your instructions happily and consistently—Gerber's Strained Foods offer these "specialties":

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Thirty different strained foods give prescription selectivity and menu-interest. They include six meats, none—even pork—with over 5% fat content.

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Gerber's delicious true flavor and true color brighten up special-diet meals.

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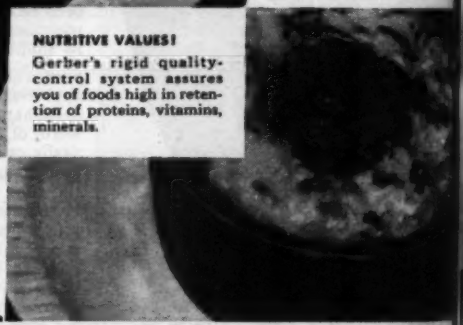
NUTRITIVE VALUES!

Gerber's rigid quality-control system assures you of foods high in retention of proteins, vitamins, minerals.



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Easy to serve... Gerber's pre-cooked foods come in convenient individual-size containers. Easy to shop for in leading grocery stores everywhere.

"SPECIAL DIET RECIPES" FREE

Includes those illustrated above—Chicken "Gumbo" Soup, Individual Meat Pie, Jellied Vegetable Salad, Fruited Rice Pudding—and many others for Bland, Soft, Mechanically Soft, Liquid, and Low-Residue Diets. Write on your letterhead to Dept. 226-2, Fremont, Michigan.

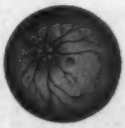
Gerber's BABY FOODS

4 Cereals • 50 Strained and Junior Meats, Vegetables, Fruits, Desserts

EXTRA PROTECTION

FOR YOUR CARDIOVASCULAR PATIENT

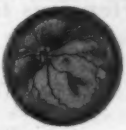
Normal. Capillaries clearly defined; no transudation, hemorrhage, or papilledema.



RUTAMINAL* provides the extra protection of rutin and ascorbic acid...in support of the cardiotonic action of aminophylline, and the sedation of phenobarbital.

Borderline. Capillaries show irregularities, slight transudation. Incipient papilledema.

Abnormal. Capillaries tortuous, with areas of hemorrhage and transudation. Papilledema.



RUTAMINAL...

Whenever aminophylline and phenobarbital are indicated...

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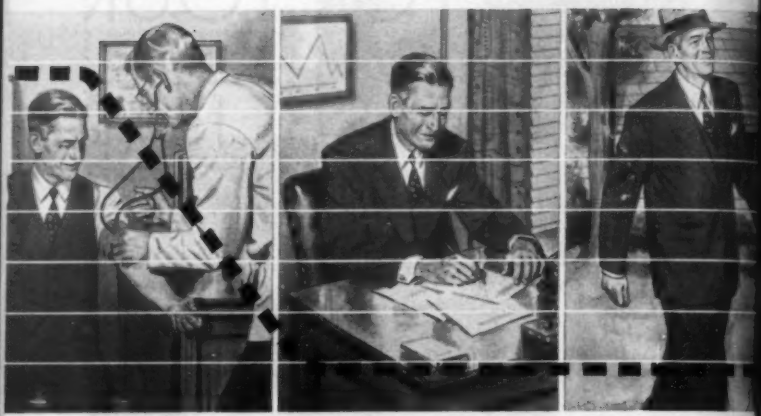
Isn't this the pictur



Nitranitol's safe, gradual, prolonged vasodilation permi hypertensives to resume more normal lives

What's more, therapeutic dosages of NITRANITOL can maintained over long periods of time . . . *without* freque checkups . . . *without* worry about possible toxic effects.

Is it any wonder that NITRANITOL is the universally pr scribed drug in the management of essential hypertensio

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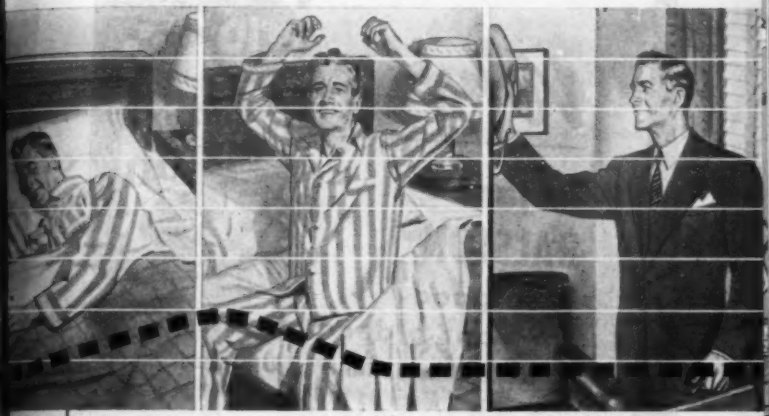
New York • CINCINNATI • Toronto

you want to prescribe...

for your hypertensive patients?



When vasodilation alone is indicated. *Nitranitol.* (¼ gr. mannitol hexanitrate.)

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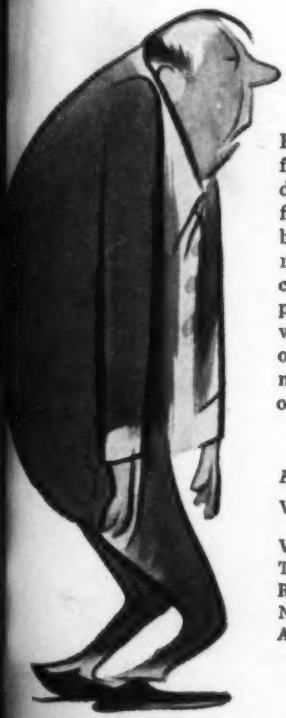
NEW . . . For refractory cases of hypertension. *Nitranitol P.V.* (¼ gr. mannitol hexanitrate combined with ¼ gr. phenobarbital and 1 mg. Veratrum viride alkaloidal fraction – biologically standardized for hypotensive activity.)

NITRANITOL®

Sick people need nutritional support

specify **THERAGRAN**

Therapeutic Formula Vitamin Capsules Squibb



Even if an optimal diet is prescribed for — and eaten by — the sick person, diet alone will not correct vitamin deficiencies rapidly. Theragran will help bring earlier and more satisfactory recovery after surgery, will help to correct dietary deficiencies among patients who are "bad eaters," and will add greatly to the effectiveness of the therapeutic and supportive measures in patients who are older or chronically ill.

Each Theragran Capsule contains:

Vitamin A (synthetic)	25,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Thiamine Mononitrate	10 mg.
Riboflavin	5 mg.
Niacinamide	150 mg.
Ascorbic Acid	150 mg.

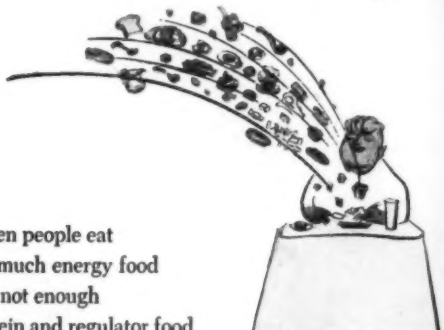
Bottles of 30, 100 and 1,000

see following pages . . .

SQUIBB

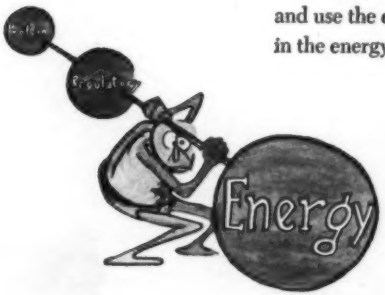
"Diet Instructions"
your patients' guide to better diet

You need to watch what you eat



When people eat
too much energy food
and not enough
protein and regulator food

...they do not get enough
protein, vitamins and minerals,
which they need to keep well
and use the energy
in the energy foods.



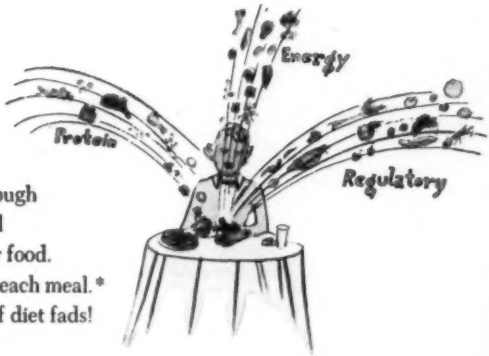
Then they may
need large quan
of protein,
vitamins or min
to get well.

...see preceding page

This is a reproduction of pages 6-7 from "Diet Instructions," a new practical guide to better diet for your patients. For a supply of booklets write to E. R. Squibb & Sons, 745 Fifth Avenue, New York 22, N. Y.

see following page . . .

You need to watch what you eat



You must eat enough protein food, and enough regulator food. Try to do this at each meal.* Avoid all kinds of diet fads!

*You may eat food hot or cold, raw or cooked, fresh or frozen, canned or dried, unless special instructions are given.

protein foods

energy foods

regulator foods

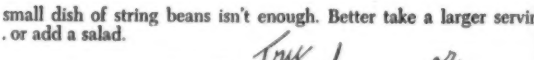
SQUIBB

"Diet Instructions" show your patient how much is enough

Toast and coffee isn't enough to start the day on. It's better to add vegetable or fruit juice and an egg.

A small piece of meat doesn't give you enough protein. Increase the size of the portion of meat, or also eat some other protein food, or drink milk.

A small dish of string beans isn't enough. Better take a larger serving . . . or add a salad.



A lettuce leaf and slice of tomato doesn't really count. You need more regulator food . . . such as raw cauliflower chunks, sliced carrots, or cucumber rings.

"Diet Instructions" is the new simply written guide to better eating habits for your patients. To obtain a supply just write to E. R. Squibb & Sons, 745 Fifth Avenue, New York 22, N. Y.

. . . see preceding pages

SQUIBB

Editorial

Blue Shield Loopholes

"What damn good is my health insurance, anyway, if it won't pay my doctor bills?"

One more patient has just discovered that his Blue Shield policy doesn't cover home calls—or physical exams, or lab procedures, or minor office surgery. And he's all het up about it:

"You doctors sponsor this insurance, don't you? Then why not give *complete* coverage? These loopholes make me sick!"

What patients don't realize is that there are two types of loophole—one bad, one good. If *major* medical expenses are excluded from coverage, that's bad. And it's clearly up to medicine to see that loopholes of this type are plugged as quickly as possible (for example, through catastrophic coverage).

But it's also up to us to make patients understand why the other type of loophole is *good*. For when *minor* medical expenses are excluded from coverage, it may well save the patient money.

How come? Because of the cost of processing claims—about $3 per claim, according to one report. This handling charge doesn't bulk large in the case of, say, a $100 appendectomy. But what about simple home and office calls?

A $6 service might easily cost $9 if paid for through Blue Shield. That's been the experience of most plans trying out small-claim coverage, Dr. Paul Hawley reports. Under these circumstances, as Blue Shield's former chief executive points out, minor medical services are apt to cost 50 per cent more than they're worth. *And it's the subscriber who eventually pays,* through premiums swollen beyond all reason.

"Thus we encounter the law of diminishing returns," says Dr. Hawley, "when we attempt to insure against the costs of small medical bills. The same situation would obtain in government compulsory insurance, thus greatly increasing the cost of medical care."

Under almost any conditions, it seems, insurance against minor medical costs may turn out to be a bad bargain. The average person will usually do better to pay small bills out of his own pocket.

To most people, actuarial principles are a world apart. But if we occasionally take two minutes to bring this one down to earth, we'll be doing our patients a service—and taking ourselves off the spot.

—H. SHERIDAN BAKETEL, M.D.

When the Tax Auditor Comes

Here is what the experts advise if a revenue agent wants a look at your books

● Ever seen a Federal income tax auditor?

Some doctors (who've heard it from friends) say you can tell him by his forked tail and horns. Others who've actually encountered such an auditor tell me they've come out of it unscathed.

In any event, tax auditors this year will knock at the office doors of hundreds of U.S. physicians. The main thing to do, if one of them calls on you, is:

Don't worry about it. Keep cool.

That's the advice of men who know tax auditors best: the accountants and lawyers who specialize in tax work. Chances are, these old tax hands say, the auditor you draw will be a fairly agreeable fellow anyway.

One tax consultant, connected with a medical business bureau, thinks it highly important for doctors who are visited by a tax auditor to get off on the right foot with him. If they don't—if they approach him as a natural enemy—he'll quickly sense it and they may soon be headed for trouble.

"I'll admit," this consultant says, "that among tax auditors, as among people in general, you'll sometimes run into a first-class stinker. But *most* of them are all right if you treat them right. Just don't antagonize them. Keep clear of personality conflicts."

Last year, one practitioner I heard about charged into an audit without benefit of this advice. He made it immediately clear that he was a busy man and that he considered this auditing business an annoyance and an imposition. Then, so as not to be interrupted later, he proceeded to defend certain of his deductions in advance, tartly explaining the law as he went along.

Needless to say, the tax auditor was hardly in a sympathetic mood when he turned to the doctor's records. Although the books were in good order, he checked and double-checked them with unusual thoroughness.

The audit took the better part of two days; it should have been cleaned up in a single morning. Though the auditor's extra effort cost the doctor only $86 in disallowances, it might have cost even less. And it might have taken quite a bit less question-answering time, with less

By James G. Blake

of the nervous strain that this entails.

Out of the mass of legend surrounding the tax audit has emerged the notion that a call from the tax people means a doctor is under suspicion. This is not usually so, says a professional management consultant, who reports that a tax audit hits about every tenth doctor on his roster. He adds:

Reasons for Audit

"I'd say that more than three-fourths of our clients who are audited are selected purely by chance. It's routine for a collector to check a certain number of returns; most of the doctors who are called just happen to be among those chosen. And in most cases our doctor-clients' returns are not revised as a result of the audit."

This much, however, the Bureau of Internal Revenue readily admits: Every private practitioner's return is *subject* to an audit. So are those of lawyers, architects, independent grocers, and other self-employed persons. "Whenever a return comes through with a Schedule C attached, it is set aside for possible audit," says an Internal Revenue official.

It's no secret either that high-income returns are audited more frequently than low-income ones. Rumor has it in tax circles that the day isn't far off when all returns showing a net income of $12,500 or more will be audited routinely. If this happens, more doctors than ever before can expect to have their records examined every two or three years.

Apart from the spot check, you also may meet a tax auditor this year if:

¶ Your return shows any major omission—the status of a dependent, for example, or the names of the charities you have given to;

¶ You have failed to report all dividends received (it's easy for the Revenue Bureau to check this, since corporations report in duplicate on all dividends paid—one copy to you, one copy to the Revenue Bureau);

¶ Your final return doesn't jibe with your information return;

¶ You've filed for a refund;

¶ One of your patients has made a large deduction for medical expenses and named you as his doctor;

¶ You've been audited in the past and have had some major claims disallowed.

How You'll Hear

If you're pulled out of the tax collector's grab bag, you'll find a long white envelope in your mail one morning. It will be a letter—business-like but cordial—requesting that you call your district Internal Revenue office for an appointment.

Usually—especially during the tax department's harvest season—you'll be asked to report to the collector's office with your records. But if this is inconvenient or impracticable, the collector will arrange for a field audit. And soon afterward you'll have

Steady Now, Let's Keep Our Balance

e of his agents visit your office. How long he'll stay depends mainly on what sort of records you keep. If your books are complete and well organized, it may all be over in two or three hours. Otherwise, the audit may take as much as several days.

Where Trouble Starts

One unhappy physician had an auditor around for more than a week. The trouble: He couldn't produce canceled checks or paid receipts for a $116,000 building he'd put up for investment purposes. When he wasn't trying to answer the auditor's questions, this M.D. spent his valuable time scurrying around to the plumber, the electrician, the contractor, and others who could help substantiate his expenditures.

Finally—but too late—he called in a tax specialist. Together they accounted for about three-quarters of the sum he'd spent. The doctor is still taking a considerable annual loss because the depreciation rate on his $116,000 building had to be based on a lower property value.

Most physicians will not find the tax audit quite so unpleasant as that. Actually, you don't have to be present during the entire audit. If it takes place in your office, you need only welcome the tax man, lay out your records, and be prepared to answer an occasional question. If your books are in tiptop shape, you may not be bothered at all; except, of course, that the necessity of having to remain close at hand for a while may disrupt your normal routine.

Any M.D. may ask a tax adviser—usually an accountant or lawyer—to represent him during the audit. In this event, the doctor may not even have to meet the auditor. Not only can an accountant or lawyer relieve you of a time-consuming annoyance, but he may also be able to get you a better break. The competent tax adviser knows what the auditor is after, and sometimes he may even know the auditor himself.

Even when you have a tax adviser, though, there's a chance that the auditor will want to talk to you, if only for a moment. Tax auditors often profess to be students of human nature, and a brief conversational exchange may be their way of sizing you up. Needless to say, it's wise to be cordial.

Loaded Question

Different tax men use different psychological gambits on doctors. Some are exponents of the leading question—one designed to catch the M.D. with his guard down. Once, during a casual conversation, an auditor asked, "How much does the average doctor make a week, anyhow?"

When the physician answered, the tax man mentally multiplied by fifty-two. Had the physician's listed income been radically different from this calculation, the auditor would doubtless have gone over the doctor's records with a microscopic view.

In the final analysis, it's your

books themselves that matter. Usually, the tax auditor works in three stages:

First, he matches your stated income against your record of receipts.

Second, he calculates your professional and living expenses.

Third, he spot checks your canceled checks and paid bills to see if they coincide with your disbursement records.

Records Required

By helping him speed up this procedure, you'll help yourself. A little preparation will do the trick. Before the audit, for example, you can assemble your records of:

¶Fees received (including those from medical insurance plans, workmen's compensation, welfare organizations, Government agencies, etc.);

¶ Salary earned;

¶ Income from investments, savings deposits, insurance, sale of property or equipment, etc.

Make sure, also, that the following things are in order and easily available: bank statements and passbooks; brokerage house statements; dividend notices; mortgages and loan records; contracts covering professional service; partnership agreements; and anything else that relates to your income.

To help the tax men figure out your expenses and disbursements, you may have to produce records of:

¶ Salaries paid to assistants, office help, substitutes, etc.;

¶ Professional expenses (cover
rent, repairs, office supplies, medi
journals, uniforms, medical soci
dues, travel, etc.);

¶ Personal or nonprofessional d
ductions (such as contributions, b
debts, casualty losses, and state t
es).

And if you and your wife fil
joint return, don't forget to incl
her checkbook among the things
hand over to the auditor.

What happens if you don't h
these records? As an extreme
ample, consider the case of an M
who kept no records at all—altho
he did have a pretty accurate
of how much he took in and
out:

This practitioner had always co
puted his income from memory. A
he got by admirably until, one d
a tax auditor descended on him.

When the collector learned th
the doctor kept no records, he
signed an observer to the office a
made an estimate of the docto
annual income and expenses on th
basis of the observer's findings. I
made sure that the estimate wa
high, just in case the observer ha
been present during a slack period

Usually, there's little ado abou
income during a tax audit, as long a
the figures in your books check wit
those on your tax return. But whe
it comes to deductions, there's some
times room for spirited disagreemen
between doctor and auditor.

Tax experts insist that a proper
executed tax return includes ever

possible deduction—i.e., that it claims all the deductions you think you're entitled to rather than just those you think you can get.

Since the tax commissioner's rulings and the legal precedents are not always clear, it's often up to the individual auditor to decide whether a deduction is allowable. Neverthe-

[MORE ON PAGE 169]

Medicine's Lone Ranger

• In California's Saline Valley, a near-sea-level hell that makes Death Valley seem like paradise, lay a young man with a badly mangled leg. He was a crew member of an Army plane that had crash-landed in the desolate salt flat.

When Dr. George D. Shultz, some miles away in tiny Lone Pine, got word of the accident, he set out by car for the salty wasteland. Guided by flares, he traveled the rugged switchbacks to the floor of the valley. There, the roads had been washed out by flash floods, and the scene, as he puts it today, "resembled a river bottom, littered with boulders the size of a man's head."

At midnight—after five harrowing hours of travel—he reached his patient and began to amputate the leg

by the light of a rotted-wood fire. Not until 6 A.M. was he back in Lone Pine.

More than 10,000 feet up, in a Sierra Nevada mountain camp, a 5-year-old girl lay on a table in a log cabin. Over her right forehead was a long gash left by a mule's hoof that had driven fragments of bone and part of the orbit against the brain.

When the call came, George Shultz got a mule pack and started up the 25-mile, rock-strewn mountain trail to the camp. Four hours later, he was operating under gas lanterns and flashlights. The girl rested well during the night. Next day, he had to get her down the precipitous mountain side. With the aid of forest rangers ("a tall one and a short one, to compensate for the slant of the trail"), the descent took about six hours. Next day, the patient was on the road to recovery in Lone Pine's twenty-bed hospital.

For George Shultz, such exploits are all in a day's work. His bailiwick in Inyo County, Calif., is bounded on the west by the snow-capped Sierra Nevadas (near-by Mt. Whitney is the country's highest), and on the east by the "bad water" country of Death Valley (lowest point in the U.S.).

To make "house calls" in this country of giant-sized hills and dales, Shultz uses a mule pack; a station wagon (outfitted like an ambulance); and, for hops up and down the valley, his own Fairchild plane. The going is usually tough, for his domain is 235 miles long and 150 miles wide, and most of his 5,000 potential patients are widely dispersed among mountain ranges and hidden valleys.

Even so, the Inyo County G.P. manages to see an average of forty patients a day. These are mostly people of modest means: prospectors, cattle farmers, miners who dig soda ash out of dry desert lakes, and workers at the Los Angeles aqueduct, which carries water from the Sierras to the city 235 miles away.

Despite his heavy patient-load, Shultz's daily job may be only half done by each nightfall. Aside from the ordinary after-hours emergencies, he has had his share of unusual ones: a trip by horseback up 14,495-foot Mt. Whitney to help a blizzard victim in August; a visit to Two-Gun Mary Thompson's mine in the ghost town of Panamint City to see a stricken caretaker; a dash through the foothills to the shack of a miner who, under the law of the woods, has been disembowelled by a neighbor's hunting knife.

Lone Pine's far-ranging physician has been answering calls like these since 1936, when he first went to the remote valley. For the 42-year-old "emergency doctor," these have been sixteen years of hard work—yet with more than a normal quota of thrills thrown in.

His biggest handicap, he says, is his "lack of able assistance." From time to time, he has been able to entice a young doctor into the

mountain-walled valley. But for most of the sixteen years he's had to go it alone. "Many times," he says, "I would have given anything for some good consultation, an anesthetist, a surgical assistant." When these aren't available, his wife Hazel sometimes pitches in and helps him.

George Shultz found himself in a real spot back in 1943. That was the year when Lone Pine's small hospital went bankrupt and closed its doors for good. But in the area around Saline Valley a man gets used to scrambling over obstacles. So within two months, the town had another hospital, despite wartime scarcities.

With the help of the townsfolk, Shultz had converted an abandoned garage that was on the salvage list. He's rightly proud of the place today. In particular, he enjoys showing visitors its hot water sterilizer, made from a restaurant-size coffee urn.

Does he ever regret having set up a practice in this tiny desert town?

"Only rarely," he says shaking his head. "Like, for instance, when my brother Bill drives through in a shiny new Cadillac. Or when my brother Ellwood [a Los Angeles industrial surgeon] asks me on a cruise around the coastal islands in his yacht. They always tell me: 'You owe yourself a vacation.'

"Sometimes we do get away for a week-end, but when I'm tempted to stay longer, I remember that hysterectomy scheduled on Monday morning before office hours. Or I begin to worry about Mrs. Jones, hoping she hasn't gone into labor yet. Or about that 12-year-old whose right tonsil fossa was oozing slightly last time I saw her."

George Shultz smiles, and he looks almost sheepish as he says, "I dunno. Somehow I'm always a little glad to get back to Lone Pine." END

Distal View

• The professor of surgery at a large medical center had just completed a brilliant, hour-long operation. As usual, he'd had the copious aid of the house staff, including a new interne who, back among the third tier of assistants, had been permitted to hold the distal end of a long retractor.

"Well, my lad," the surgeon asked him, as the team rested in the dressing room, "did you learn anything this morning?"

"Yes, sir," the interne answered wearily. "I can now state with considerable assurance that the assistant resident has dandruff."

—MARVIN L. THOMPSON, M.D.

Convention Portraits

Sample Collector

Wife Trailer

Office Seeker

State Booster

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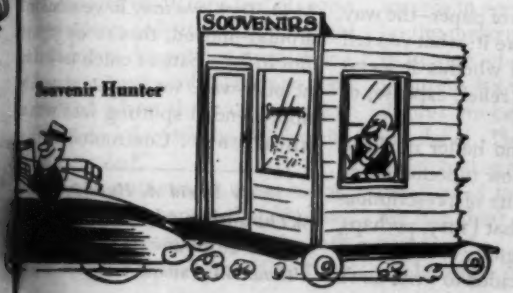
Relaxation Finder

Hem Toucher



Souvenir Hunter

Honest-to-God
Knowledge Seeker

Your Prescription As the Patient Sees It

Are you up on the fine art of Rx writing?

● What does the patient have when he leaves your office that he didn't have when he came?

Chances are that he feels, physically, about the same as before, that his hemorrhoids and hypertension are still with him. So you can't really blame him for thinking of the prescription you hand him as the one tangible result of his visit. Or for judging you to a considerable extent by that slip of paper—the way he sees you prepare it; what you tell him about it; and whether it seems likely to produce relief, expense, or mere nuisance.

I'm probably no better qualified than the next fellow to sound off on the common sins of prescription-writing—except that I may, perhaps, have been more guilty of them. But not long ago I decided to write down my ideas on the subject, then t them over with a few colleagu For what my gleanings are wor here they are:

How, to begin with, can a doc prescribe accurately without be fit of medical texts? That's a pr lem all of us must face. The lawy lucky fellow, is allowed to pull do a legal tome from his shelves wh a client asks him a poser. Not so t M.D. True, we may have some te around—indeed, they're *de rigue* But to let a patient catch us lookin at one—well, we might as well b apprehended splitting fees with a abortionist. Confronted with s

---

By David A. Henderson, M.D.

**The author, who writes here und a nom de plume, is an active pra titioner in a small Virginia city.*

many different brands and dispensatory characteristics of the same drug that a quiz kid couldn't remember them all, we must still go on composing every prescription by rote.

Or must we? Many a doctor now gets around the problem this way:

He keeps some such drug directory as the Physicians' Desk Reference within easy reach. Then, as he leafs through its listings, he can tell the patient something like this: "You'll need sixty-three capsules for a week's supply. No use making you pay for more than you really need, so let's see what quantities they pack them in." Thus his glance at the directory is justified in terms of his desire to protect the patient's pocketbook. It doesn't imply that he needs a refresher course whenever the time comes to prescribe treatment.

Surplus Capsules

In these days of expensive medications, the need to avoid prescribing overlarge quantities is—or should be—obvious. Yet I suppose every doctor has had the experience of ordering 200 capsules of some costly drug, only to find that the patient has to discontinue them after a few days' treatment. There's no good answer when the patient asks: "What do I do with the 191 remaining capsules?"

Every patient, it seems to me, has a right to expect that his doctor, before specifying quantity, will balance (1) the possibility that the patient will be buying tablets he'll never use, against (2) the advantages of getting a commodity in the "low-priced economy size." The medical man who prescribes an excessive amount of an expensive drug has only himself to blame if the patient does some medicine-chest browsing instead of calling on him the next time he's sick.

Getting Personal

A sure way of alienating patients is to let them think they're getting impersonal treatment. Take a prescription form used by some doctors, for example: the kind that has a medication or diet preprinted on it. Such blanks are admittedly time-savers; but psychologically they're bad medicine. Maybe you *do* use the same routine for all colds, and the same routine for all post-tonsillectomy cases. Still, the patient wants treatment for what he regards as his very own, highly individualized condition; and not for some "average" case.

Another way of making a patient think he's getting impersonal treatment is to neglect to write his name on the prescription blank. Especially in view of the legal hazard thus incurred, it's surprising how many doctors are careless about this simple detail. The druggist down the street told me recently that up to one-third of the prescriptions reaching him don't bear the patient's name.

The same druggist tells me that

many M.D.'s don't enter the patient's age in the space provided on the Rx blank. That's something I've learned to be pretty careful about, especially when I'm prescribing for a child. This precaution, of course, is designed mainly to put the pharmacist on notice in case, through some slip-up, I order an adult dose. But it also lets parents know that I've kept their child's age in mind in determining the dosage.

Write It Right

No matter how carefully an Rx is tailored to the individual, he still likes to be *sure* it's entirely accurate. I've learned to avoid some things that might make a patient doubt a prescription's accuracy. For example:

¶ Some prescriptions (particularly solutions) require a little arithmetic before the pen goes down on the Rx blank. How much medicine do you need in a four-ounce bottle if you want the patient to get two and one-half grains per teaspoonful? It's sound practice, I believe, to let the patient see you work out this little problem on scratch paper before you write the prescription.

¶ A doctor who makes a mistake while writing an Rx may be tempted to cross out the wrong word and write in the correction. But to the patient—who is probably watching the procedure with hawk eyes—such cross-outs may suggest carelessness. Naturally, it's best to get it right the first time. But if I make a slip anyway, I discard the Rx blank entirely and start again on a new one.

¶ Although it may seem a trivial thing, the habit of rereading a prescription before handing it to the patient is well worth cultivating. It establishes the doctor as a cautious fellow who invariably checks and double-checks. This the patient appreciates.

For Your Records

Another confidence-inspiring procedure is to make a copy of the Rx and to place it with the patient's permanent record. My own custom is to write the prescription into the record first, then to copy it on the Rx blank I hand the patient. The record copy may come in handy months later, when the patient returns for more of "that green medicine" that fixed him up the last time. (I know other physicians who use carbon paper between a pair of sheets in the prescription pad. They then staple the carbon copy to the patient's record form.)

When I first started out in practice, I usually wrote "Sig.: Take as directed" on the Rx blank—relying on word-of-mouth instructions to supplement it. But I soon discovered how easy it is for patients to confuse "two drops every eight hours" with "eight drops every two hours." Now I save headaches for both the patient and myself by taking a few seconds to write out the directions on the prescription blank.

Should the patient be told what

medication he's getting? This poser has been batted around medical staff rooms for years. There are advantages, of course, in letting the patient know when you prescribe such things as vitamin B or penicillin: You find out if the patient has had the medication before, whether he's sensitive to it, or whether it has proved ineffective. This approach also flatters the patient, implying that he's sophisticated and intelligent enough to share in the planning of his treatment.

On the other hand, it may encourage shopping around for cheaper substitutes. And it may have the curious effect of making the patient feel let down. "Imagine!" he might say to himself. "That guy charged $5 just to tell me I needed vitamins. A druggist would have told me that for nothing."

All in all, I'm inclined to think the turn-of-the-century doctor had something when he solemnly wrote an Rx for *pilulae hydrargyri chloridi mitis compositae,* instead of saying simply "compound cathartic pills."

Warn Your Patient

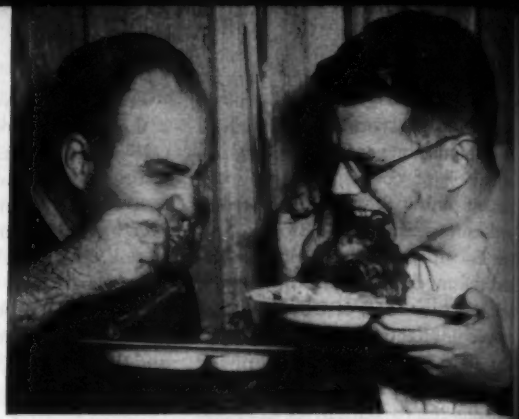
There's no question, though, that the patient ought to be told if the Rx will mean something unpleasant with respect to his taste, his symptoms, or his pocketbook. He should know in advance, for example, if the medication has an especially salty or gritty taste; such a warning will assure him he's got the right medicine when he starts taking it.

He also deserves some warning if the medication may cause odd side-effects—dizziness, for example, or green stools. And if the prescription will cost him a week's wages, better prepare him carefully for the shock. He'll probably appreciate some word along these lines: "This will be rather expensive, but I think it will get you back to work faster and thus save you money in the long run."

For Children Only

Every parent knows (but apparently some doctors don't) that children seldom take medication as directed. So before the parents leave my office, I generally offer a few words of advice to help them overcome such common obstacles as gagging, choking, and spitting. They really appreciate this advice—and, for my part, I'd a lot rather dole it out during office hours than over the phone at 3 A.M.

Although I try to answer most questions a patient asks about his prescription, there's one I *won't* answer: the request that I recommend a specific pharmacy where it can be filled. "Your neighborhood drug store is probably the best bet"—that's my stock rejoinder. I can't afford to let the patient think that any druggist pays me a commission for business sent to him. Oddly enough, the patient most likely to draw this conclusion may be the very one who insists that I make such a recommendation. END



The two birds in M.D. hands here are a traditional delicacy at all annual picnics: hickory-smoked, barbecued chicken. Last year, the druggists took their turn as host

Doctors Dentists Druggists Have Ins at Yearly Outing

● In most places, doctors, dentists, and druggists meet dutifully, whenever necessary, to iron out differences. But in Indiana's southwestern corner, they take another tack. Twice a year the three "D's" go all out for fun, and fun alone. Result: their issues rarely come to a head.

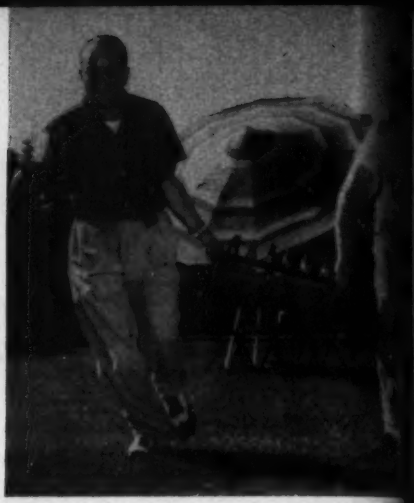
By now as traditional as spring floods and hot August, the annual Vanderburgh County outings began back in 1937 with an Ohio River steamboat excursion. The three groups voted for more—provided the joint parties "were held on something you couldn't fall off of."

Today, these "D"-Days are unbuttoned stag affairs on dry land. Indoors in winter, the druggists treat doctors and dentists to a dinner in Evansville. In summer, it's the kind of free-for-all sampled here by the camera.

A by-product of these social activities is a year-round "atmosphere of friendliness," say local professional society officers. A druggist, for instance, never finds himself behind the eight-ball over a telephoned narcotics prescription. In fact: "Most issues that ordinarily cause friction and ill-feeling never get to the problem stage."

For those who don't shoot the breeze in the shade there are clay pigeons to shoot in the sun. Annual sports highlight, though, is a three-way baseball tournament. Below, Druggist Syl Stratman, the umpire, calls Dr. Keith Meyer safe at home, as Druggist-Catcher Houch Houton fails to tag him.

Doctors, Dentists, And Druggists *(Cont.)*



Thirst aid on emergency footing is prescribed for overheated bas rookies by two druggist-hosts. Last year's picnic took place on the y hottest day (102 in the shade), but the turnout reached a total of

Until a moment ago, Druggist Ed Rinderknecht and kibitzers had wo dered why he was so cold at poker on so hot a day. Temporary loser Druggist Ted Long (left), Dr. C. R. Buikstra, and Dentist C. J. Hawkins

Borrowed horse-race wheel is one way to foot picnic bill. When M.D.'s are hosts, they tap medical society treasury.

Dentist nine copped the baseball trophy from dethroned titleholders, the M.D.'s. Here Druggist Bob Leich awards his firm's cup to dentists' co-captains. Losing team's captain, Dr. Bill Denzer, looks on.

END

Fee Splitting: How to Combat It

It's an uphill battle, but some crusaders have won out

● In spite of all the efforts that are made to combat it, fee splitting is still prevalent. It may even have increased in recent years. Contemplating this discouraging fact, some doctors have concluded that fee splitting is inevitable and that you may as well relax and go along with it.

Remove the ethical and legal barriers to fee splitting, these men say. Make it open and honest. Then try to regulate the practice so nobody gets hurt.

This sounds suspiciously like surrender to evil. The rule, "If you can't beat 'em, join 'em," is perhaps an occasionally acceptable tactic in business and politics. It cannot, however, be tolerated in a profession when it involves the sacrifice of moral principle.

Most doctors who have thought seriously about the problem acknowledge that a moral principle is at issue. The principle: It is right to consider the patient's welfare in deciding who shall do what in diagnosis and treatment; and it is wrong to consider anything else—such as who gets how much money. According to Dr. Malcolm T. MacEachern, former executive head of the American College of Surgeons and present professional relations director of the American Hospital Association, fee splitting "is not only a disregard of a most sacred confidence, but it is a breach of trust, as that expression is interpreted in modern business."

Apart from the question of right and wrong, it probably wouldn't do much good to legalize referral fees or commissions in medicine. No system of open referral fees would do away with secret "splits behind the split." Once the principle was sacrificed and the idea of medical commissions accepted, there could be little restraint on secret kickbacks.

By Robert M. Cunningham Jr.

**This is the third and last of a series of articles by Mr. Cunningham. The first—a discussion of the whats, whos, and whys of fee splitting—appeared in the April issue of* MEDICAL ECONOMICS. *The second, in May, dealt with the ethical and legal implications. In future issues, this magazine will present additional articles on the problem, including a defense of fee splitting and a report on its relation to Blue Shield.*

"Ethical fee splitting would not remove the incentive to split in secret," Dr. John W. Sherrick of Oakland, Calif., has pointed out. "Unscrupulous specialists would continue to gouge the public simply by adding the split to their charges." Surgical fees would go up, to cover this added "cost of doing business," and patients would take it on the chin as well as in the abdomen.

One City's Experience

Happily, there is evidence that surrender to evil is unnecessary. Fee splitting is *not* inevitable when it is attacked head-on by resolute medical men who are willing to act against fee splitters instead of just talking about them. One of the first demonstrations of this fact came from the Columbus Surgical Society in Columbus, Ohio.

Columbus was once known as a fee splitter's paradise. There, it was reported a few years ago, a general practitioner refused to see a patient who telephoned at night, referring him instead to the emergency room of a hospital. The resident on duty at the hospital called in a surgeon; and the general practitioner—who had done nothing but answer his telephone—demanded a split of the surgeon's fee! In Columbus, "commercial surgery" was a definitive term, as "orthopedics" and "gynecology" are elsewhere.

Six years ago all that was changed. After months of study, a small band of surgeons who were fed up with fee splitting organized the Columbus Surgical Society. This organization appeared to follow the standard pattern of scientific and educational societies, but it was actually different in one vital detail:

Members had to sign a pledge not to split fees, and they also had to agree *to submit their books, including income tax returns, to annual inspections made by a firm of certified public accountants hired by the society.* In addition, the organizers got voluntary hospitals to agree that society membership was desirable for surgical staff appointments.

How did the founders get split-happy surgeons to join a society that soon came to be known, contemptuously, as the "Purity League"?

Actually, it was a slow process at first, according to the organizers. One at a time, they started buttonholing their surgical colleagues and persuading them that drastic action had to be taken. Soon the original four became six, then eight, then ten.

After that, the joining picked up speed, like a political bandwagon. Eventually, 95 per cent of the city's surgeons were Purity Leaguers.

The Plan Worked

In a letter to a medical friend in another city, a Columbus Surgical Society member who has been active in the program explained, not long ago, how the plan was working out:

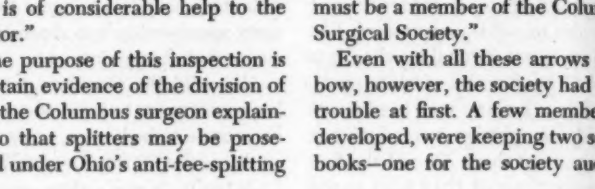
"The auditor has the right to seek

evidence of the division of fees at any place in the member's account," he wrote. "He has complete access to the books, account cards, income tax returns, bank accounts, and any other data which he chooses to investigate. We have an auditing committee, made up of members of the society, which assists the auditing firm in making the audits. If there is a question of the division of fees, it becomes apparent sooner or later how this is being accomplished. This is of considerable help to the auditor."

The purpose of this inspection is to obtain evidence of the division of fees, the Columbus surgeon explained, so that splitters may be prosecuted under Ohio's anti-fee-splitting law. Actually, legal prosecution hasn't been necessary. Here's why:

"We have succeeded in gaining the cooperation of hospitals to the extent that they encourage membership in the Columbus Surgical Society as a basic requirement for surgical staff membership. All the hospitals in Columbus, except one, have agreed to this provision, and we hope to gain their cooperation within a reasonable time. In order to practice surgery in Columbus a man must be a member of the Columbus Surgical Society."

Even with all these arrows to its bow, however, the society had some trouble at first. A few members, it developed, were keeping two sets of books—one for the society auditor,



"Hmmm . . . sounds like a vitamin pill deficiency."

and one for the Collector of Internal Revenue.

Countering this maneuver, the society invited the collector into the act with a resolution to the effect that the division of fees was not a business necessity and for that reason should not be considered a just deduction for income tax purposes. The society urged the collector to deny all such deductions and offered to give testimony against splitters who claimed them.

That's when the roof fell in on the remaining fee splitters in Columbus. "In the first two years three men were found to be using the double book method and declaring the division of fees as a deduction for tax purposes," the Columbus surgeon related in his letter. "Two of these men paid small assessments—approximately $10,000 to $15,000. The third man, however, had a tremendous surgical practice. He received a severe investigation, with a charge of fraud. The Bureau of Internal Revenue liquidated his assets and ended up with an uncollected assessment of approximately $150,000 against him."

Any Loopholes?

Told about the Columbus plan, doctors elsewhere are likely to scoff and point immediately at what seems to be a gaping loophole: What's to prevent members from collecting their fees in cash, without keeping any records, and splitting as they please—that is, if they're willing to risk tax penalties for concealing income?

Of course, nobody can say with certainty that this never happens; but Columbus surgeons are convinced there isn't much of it done today. The reason is that hospital operating schedules are open for inspection by the society's auditors. By counting the operations performed by any suspect surgeon and checking these against the bills he *has* issued, the auditor can quickly pinpoint questionable cases. If the surgeon won't talk about these, the chances are good that the patients will; most of us love to talk about our operations—*without* being asked.

Actually, two men were picked up for falsifying income statements early in the operation of the Columbus plan. One of the men was heavily fined, and the other died of coronary thrombosis during the investigation. Since that time, Columbus doctors feel certain, not many of their colleagues have risked getting caught with unreported income.

Experience at Columbus has led some authorities to believe that the Bureau of Internal Revenue is one agency that can succeed, where all others have failed, in eliminating fee splitting. At today's high tax rates, these authorities point out, no surgeon can afford to pay the tax on his full income and at the same time pay referral commissions, without deducting the latter as "ordinary and necessary business expense."

But, though collectors in Colum-

bus and elsewhere have disallowed splits as being against public interest, it is by no means certain yet that this represents nationwide bureau policy. In a recent case involving tax deductions claimed by an optical company for kickbacks paid to referring physicians in 1943 and 1944, the U.S. Supreme Court ruled that the kickbacks *were* ordinary and necessary expense, because at that time "there were no declared public policies proscribing the payments which were made . . . to the doctors."

By this logic, presumably, deductions for splits might be disallowed today only in the twenty-three states having laws against fee splitting. Doctors in the remaining states thus could continue to split and split, and deduct and deduct, without interference from the tax collector.

When Hospitals Help

They might get into other difficulties, though. On rare occasions, staff members of the American College of Surgeons have found an unexpected ally in hospital boards willing to take a strong stand against fee splitting.

After many years of combating fee splitting by pledge, exhortation, and reliance on the belief of Euripides that "Time unmasks the villain soon or late," the college recently has been taking a more and more active part in the institution of specific corrective measures. These have even included calling hospital staffs and trustees together in frank, get-it-out-in-the-open-and-face-it sessions. And from such meetings have come anti-fee-splitting agreements with teeth.

The teeth are provided by hospital trustees who will withdraw staff privileges from doctors who split fees. Whether such agreements can prove effective without the added feature of an audit to detect fee splitting, however, is doubtful. In some cases, the college has been successful in getting provision of an audit included in the agreement. Those teeth can bite.

Sometimes they bite back. A few months ago, doctors on the staff of St. Joseph's Hospital at Bloomington, Ill., refused to approve changes in the staff by-laws, including a new fee-splitting pledge and new regulations for the control of surgical privileges. The changes had been recommended after an inspection by the American College of Surgeons revealed evidence of fee splitting at St. Joseph's and another Bloomington hospital.

The fee-splitting section of the new by-laws included provisions under which each doctor would annually have to submit an accountant's or lawyer's sworn statement that his books showed no evidence of fee splitting. If such statements were not satisfactory, the by-laws provided that the hospital could inspect the doctor's books.

It was this last provision that

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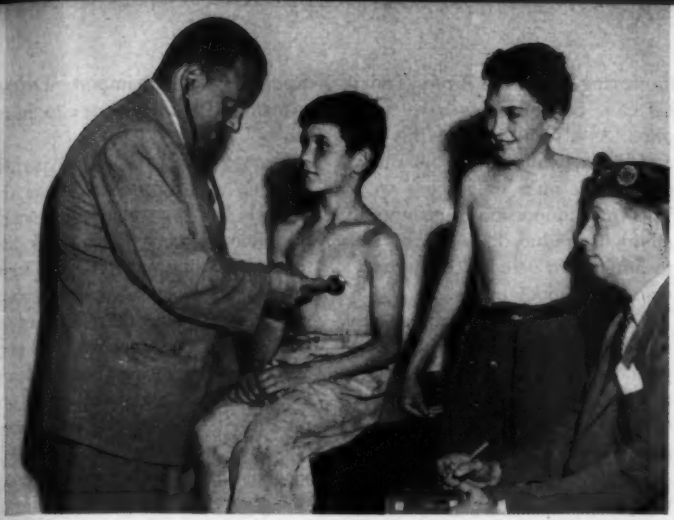

Of his hundred-odd civic activities, Dr. Schwartz is most enthusiastic about those involving kids. Here he examines boys for free summer camp.

Bachelor From the Bronx

George Schwartz hasn't time to get married. He's too busy providing the civic leadership many M.D.'s are too busy to provide

• People who know 48-year-old George Schwartz take his bachelorhood for granted. It's hard enough to picture any physician engaged in such an astonishing assortment of community activities. Nobody can quite believe that, in addition, he could manage a wife and family.

Dr. Schwartz agrees. He has pursued his energetic way free of feminine distractions ever since he quit being president of the Bronx (N.Y.) Camp Fire Girls. "I *had* to give up the girls," he says. "I was also scoutmaster of Troop 221, Bronx Boy Scouts. Some of my boys regarded the Camp Fire business as treason."

That was in the early Thirties, when Schwartz was committed to only a half-dozen projects aimed at

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By Don Cameron

improving life in the Bronx. Today, his civic commitments have multiplied. As a result, he sees his married sister, whose home he shares, only about once or twice a week. This total immersion in community affairs has reduced him, by his own reckoning, to one of the world's worst matrimonial risks.

He finds his romance, apparently, in working with people in the aggregate. Through his leadership in a score of local activities, a big percentage of the 1.5 million residents of the Bronx are healthier and safer. And from his mid-Manhattan office, where he has a lively private practice, he helps run a variety of other civic projects, some of them national in scope.

A physician once defined the Schwartz Theory of Infinite Expansion of Medical Men's Capacity for Community Service. Wittily but with complete seriousness, he put it thus: "The more items in a doctor's work schedule, the more interstices for wedging in extra activities, which will create additional interstices for additional activities, and so on, ad infinitum."

Let George Do It

Actually, Schwartz is well aware of how little time and effort the average doctor can spare for causes off his professional beat. Yet somebody has to do it, he believes: "Doctors have left civic service too much to others. There's no corner of life where their special knowledge and experience can't be important to the community—and hence to themselves."

George Schwartz is the perfect example of this philosophy in action. He has long since lost count of the civic projects in which he has taken a leading part; but last summer his American Legion post, plugging him in an election, listed twenty-two. Without racking his brain, Schwartz can, on request, rattle off as many again, including a new appointment to the Legion's ten-man National Rehabilitation Medical Advisory Board, and the vice presidency of the Bronx Chamber of Commerce.

With some digging, the civic items on this doctor's dossier can be boosted well above the hundred mark.

Bachelor's Children

For a confirmed bachelor, George Schwartz has an extraordinary partiality toward youngsters. One of his great enthusiasms, for example, is the Police Athletic League. As its medical director, he has a hand in the physical welfare of some 100,000 New York City boys and girls between the ages of 7 and 21.

And every summer, sitting hour after hour in the old Bronx Borough Hall, he radiates a genial glow as he thumps and quizzes shirtless kids bound for Boy Scout and veteran-sponsored camps. With equal warmth, he directs a thirteen-week summer safety campaign, again

aimed mostly at kids. He runs this campaign in his capacity as surgeon general of the New York Life Saving Service, a semi-official volunteer organization that maintains rescue stations at public beaches and park swimming places.

His work with youngsters may even involve matchmaking. This bit of intelligence, from an independent source, concerns a teen-age romance discreetly steered by Schwartz to the marriage altar. "Cupid had already done his share," said this informant. "The girl was pregnant. Neither she nor the boy were really bad—just scared of the responsibility and more so of their families. George and the others ironed things out, and when the kids took the vows I believe they really meant it."

Racing the Clock

A glance at any day in Schwartz's life does little to dispel the awe his schedule inspires. Take a recent Thursday. Schwartz started it by going to bed at 1:30 A.M. after driving 180 miles to and from Monticello, N.Y., to address the Sullivan County Medical Society on the value of community programs.

Usually he's up at 6, but this morning it was earlier. Following his uptown hospital rounds, he had to be downtown at 10. As public relations chairman of the coordinating council of New York City's five county medical societies, he wanted words with the traffic commissioner. Subject: Reasonable consideration for physicians making professional calls when they found it impossible to comply with parking regulations.

That meant an hour's setback in his regular 10-to-1 sessions with private patients. He had to hustle to make a 2:30 meeting at the offices of the Medical Society of the State of New York. The subject was the same, and at 3:45 Schwartz went into it further with the police commissioner at headquarters in Center Street.

It was a single-theme day, but the swift pace was typical. Leaving Police Headquarters at 5, Schwartz looked forward to dinner and a quiet evening dictating letters and reports to a recording machine in his office. "Luckily, this isn't one of the nights I'm slated for a talk," he remarked. "I'd like to knock off around 10:30 and get to bed early for a change."

Not that he doesn't enjoy his three or four evening talks a week—to M.D.'s on public relations; to civic clubs on community topics; to parents on health; and to any group that will listen (including hostile left-wing contingents) on the subject of socialized medicine.

Lesson for Leftists

Some time ago, he unleashed his all-out attack on the Ewing Plan before a section of the Communist-sponsored International Workers Order. "I gave them both barrels and tried not to look as jittery as I felt," he recalls, smiling rather grimly. "I was surprised at not being

howled down; and I was virtually bowled over when one of the I.W.O. leaders later said I'd half-convinced him. He still wanted socialized medicine, but not Oscar Ewing's brand."

This sort of thing has made George Schwartz a phenomenon even to his colleagues. Says one:

"When a man deliberately scales down a big practice to give himself more time to work harder for others, he isn't fooling. Schwartz has done that. Our society's program is successful because everybody pitches in. But without Schwartz's example, you can imagine how different it might be."

Other local leaders put it even more strongly. "He's the old-fashioned family doctor modernized and atom-powered," says Walter J. Holmes, executive vice president of the Chamber of Commerce. "And his family includes everybody in the Bronx."

"When I call him one of the most successful men I know," adds William A. Stumpp, borough Boy Scout executive, "I'm not talking about the popular notion of financial or social success. Most people look forward to being able to loaf. George's success has set him free to work harder than ever. He's repaying society with interest for every break it ever gave him—and he's having the time of his life doing it."

The Bronx was a staid community of a mere quarter-million when George Schwartz's family brought him over, at the age of 2, from Berlin. He made his first mark with the Boy Scouts, moving from tenderfoot to Eagle Scout in the shortest possible time. He stuck with the Scouts through high school and New York University, later becoming official doctor for the Bronx Council summer camps up the Hudson.

Local medical men did not at first share Schwartz's enthusiasm for community activity. Their conservatism demanded that a physician perform his good works so unobtrusively that they were barely noticeable. "To the public of that era," explains Schwartz, "the doctor's presence invariably meant some sort of catastrophe."

So he worked as unobtrusively as he could with the Scouts, with the Lions Club cancer clinic, and with the Chamber of Commerce. Then twenty years ago this Fourth of July a tragic burst of fireworks brought him out into the open.

Schwartz was at the Boy Scout camp when a boy from near-by was brought in. The youngster had lighted a firecracker, then looked to see why it hadn't exploded. Both his eyes were gone.

It was Schwartz's first bad accident case, and it shook him hard. It shook others, too, by the hundreds and thousands, before he let them forget it. He didn't rest until he had organized the Bronx solidly for battle. Schwartz spoke for all of them before the State Legislature.

Strong lobbies opposed a bill that

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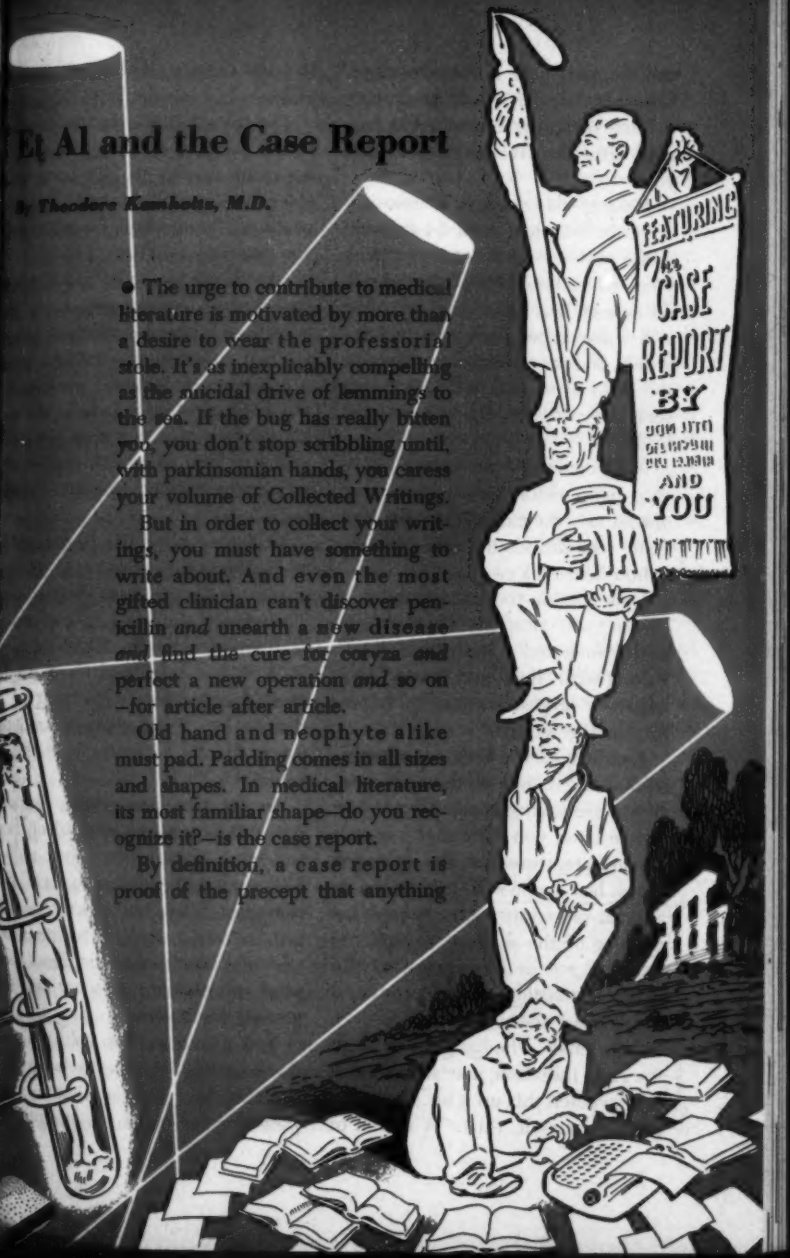
Et Al and the Case Report

By Theodore Kamholtz, M.D.



● The urge to contribute to medical literature is motivated by more than a desire to wear the professorial style. It's as inexplicably compelling as the suicidal drive of lemmings to the sea. If the bug has really bitten you, you don't stop scribbling until, with parkinsonian hands, you caress your volume of Collected Writings.

But in order to collect your writings, you must have something to write about. And even the most gifted clinician can't discover penicillin *and* unearth a new disease *and* find the cure for coryza *and* perfect a new operation *and* so on—for article after article.

Old hand and neophyte alike must pad. Padding comes in all sizes and shapes. In medical literature, its most familiar shape—do you recognize it?—is the case report.

By definition, a case report is proof of the precept that anything

can happen and eventually does. Coincidentally, it's apt to feature the first patient you meet in the hospital after the literary fever hits you.

Having selected your case—trichinosis, let's say, in a 24-year-old white male—you must next pick your co-authors. Note the plural. Of course, it is you (singular) who will write, type, and proofread the article. But for publication purposes, the chief of service, who has never seen the case, gets top billing in the by-line.

Next comes the attending physician, who made rounds once and almost saw the case. Then the associate, who *did* see the case and contributed several grunts.

Low man on the totem pole is, of course, you—properly thankful not to be included merely as "et al" (along with "ibid" and "anon," perhaps the largest authorship fraternity in the world).

Leading off the article is your introductory review of the literature. If you are saving yourself for a solo article later, you state that a search of the literature "of the past ten years has neglected trichinosis in 24-year-old white males, though incidence of the disease in such patients is not as uncommon as the meager attention it has received would lead one to believe."

Your chief, who has gone through the same initiation, may suggest that you sweeten this up a bit. If so, you extend yourself, thus: "A search of the literature of the past twenty years . . ."

The question of what reference you've used is a touchy one. It is not quite cricket to lift someone else's bibliography intact. Besides, you don't know where *he* got it; and you certainly don't want to fall victim to the reader who insists upon checking all references and who may then write the editor to point out that an article you've cited (presumably on trichinosis) deals actually with impotence in bald-headed men. Although a nuisance, then, it is probably best to include only those references you've validated yourself.

You've reached the peak of successful writing when your bibliography is longer than your article. This gives your work an impressive mathematical flavor: "Trichinosis [23, 4, 97] has been said [81, 56, 27] on several occasions [5, 32, 74] to be a disease [108, 69, 13] characterized by fever, [77, 10, 15] pain [11, 43, 91] et cetera [16, 96, 103, 111]."

As for the case itself, you describe it in a series of rigid clichés following a procedure not unlike filling out a life insurance form. For example: "This was the *n*th admission of an *x*-year-old *white male* who was admitted to the *Blank* Hospital complaining of *fever and migratory joint pains.*"

You go on in this vein until, in due course, "he was discharged on the *n*th day after admission, *completely relieved of his symptoms.*"

It is wise not to depart from this classic form, unless you want to wind up in the Reader's Digest and out of your local society.

It is likewise *de rigueur* to make the patient seem as controlled as a test tube in the laboratory. You say nothing about your discovery, following a sugar tolerance test one day, that the patient had eaten breakfast beforehand. Nor do you mention the BMR that was done while the patient in the next bed delivered precipitously. Nor the sputum report that came back marked "No free acid."

In a report case, then, there are no Sunday visitors, no temperamental orderlies, no misplaced specimens, no recalcitrant patients. This requires a kind of vigorous selectivity; you must omit every detail that even smacks faintly of the human touch.

Your laboratory reports, on the other hand, must omit *nothing*. They must include every test that was performed, whether it had anything to do with the case of not. For one thing, you may as well get credit for your thoroughness. For another, someone is always ready to pounce on that lone missing test as the really important one. You're damned if you didn't perform an opsonic index; and you're damned if you did—but more faintly.

The muttered oaths directed your way from the laboratory itself are something else again. They're a tribulation to be borne during the clinical rather than the literary work-up of the case.

The next major division in the article comes under the heading of *Discussion*. Here you may—indeed, must—divulge your motive for writing the report. The medical profession does not appreciate the disease, you say. Doctors are not aware of its incidence, morbidity, mortality, curability, pathology, and so on. It has therefore occurred to you that here is a fine illustrative case to enlighten all and sundry. So runs the *stated* motive. Quite coincidental is the fact that you're going to get your name into print.

Next comes your *Summary*, a matter of delicate balance and verbal cunning. If you tell too much, the reader's interest will pall. If you tell too little, he won't be enticed either. You must show the import of your case—but tantalizingly. If in doubt, have this part of the article edited by the Coming Attractions writer at your local theatre.

Finally—the title. If you're a junior assistant, you may appropriately

head your report "Trichinosis in a 24-Year-Old-Male." If you're an assistant with some standing, you rate a more comprehensive title—say, "Fundoscopic Findings in Thirteen Consecutive Cases of Trichinosis."

The associate physician can take the liberty of writing about "The Psychodynamic Aspects of Trichinosis." The title of the attending's article is "Trichinosis: Its Cause and Cure." The chief of service simply asks, "Whither Trichinosis?"

Once your seniors have given the nod, the article should be mailed immediately to a medical journal. If postmarked later than midnight, it may fail to establish your priority. In fact, if you put it off for even as much as the wink of an eye, the same article may appear under a different title and a different authorship. This will not happen because of plagiarism but merely because genius these days is such a common thing. END

Guest Card is better news than flowers for patients at Medical College of Virginia Hospital in Richmond. It means that a friend has contributed $5 or more toward their hospital expenses. The signed card doesn't name amounts, but merely says, "You are my guest for part of your hospital visit, with sincere wishes for your early recovery." Here a patient gets notice of this dollars-and-cents bouquet from the hospital's receptionist, Mrs. Mildred Richardson.

Corrugated-glass partition permits light flow, can be employed to separ
secretary's work space and entrance doorway from patients' waiting ro

Movable steel wall partition with door unit harmonizes with the mod
furniture in this consultation room. Acoustic ceiling absorbs sound a
lessens danger of its transmission through the relatively thin partitio

Movable Walls for Your Office?

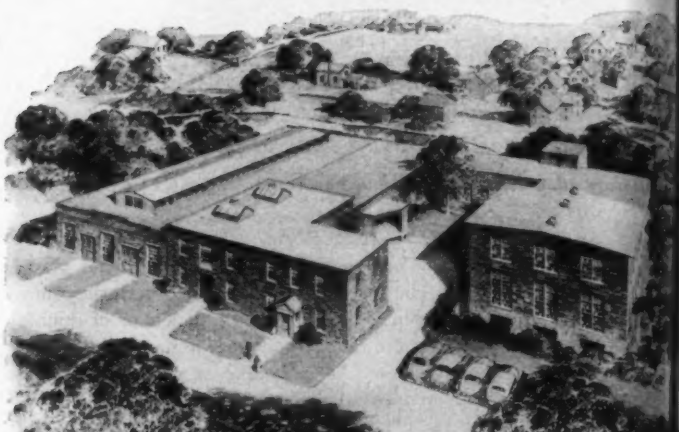
They can add flexibility and beauty in places, but they also have some disadvantages

Movable partitions are one answer to a big problem in building physicians' offices. The problem: how to build now so that later on the office plan can be easily rearranged to accommodate an expanding practice, an assistant or partner, new equipment, or new facilities.

What are movable partitions? Essentially they are prefabricated walls and door units. Built of metal, glass, asbestos, fabric, or wood, they may be thin, single panels or of double construction up to four inches thick. As half-walls or as floor-to-ceiling paneled sections, they can be dismantled and re-erected quickly and economically. [MORE→

By James C. Fuller

A steel-and-glass partition near the entrance of this reception room provides a much needed nook for the physician's secretary. Matching walls in this instance take the form of steel, double-panel, movable partitions.



THE broadening horizons of medicine make new demands on makers of diagnostic instruments. Not only are far more instruments of conventional types required, but there is an intense demand for design improvement and for the development of entirely new instruments.

To meet both these requirements, Welch Allyn has moved into the completely new home shown here, which has been planned for efficient production and elaborately equipped for research and experimental work. It is in Skaneateles Falls, N. Y., a small community 8 miles from our former home in Auburn, and gives us 4 times the floor space on a site of 30 acres. We occupy it proudly, just 36 years from the time when the first Welch Allyn diagnostic instrument was produced in a tiny one-room "factory."

In all these years, as it is today, our first concern has been to help doctors achieve accurate diagnosis through instrument quality and dependability.

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Telephone Skaneateles, N. Y. 882 Cable WACO

In what situations will movable walls work out best for doctors' offices? Remember that they are designed for flexibility. Hence, as one architect says, "They are worthwhile in direct proportion to the number of changes expected in the doctor's office."

In multiple medical offices—for example, in professional buildings and clinics—frequent and extensive changes in room arrangements may be called for. Suppose, for instance, an internist moves out of a suite and an EENT man moves in. His totally different office needs can be met quickly and cheaply by shifting the movable partitions.

One large manufacturer reports that its prefabricated walls have been installed in over 200 hospitals and medical centers. When remodeling time comes around in these institutions, once complicated jobs now seem easy. For example:

¶ Even major changes can be made in a few hours or over a weekend, often with no disturbance to anyone.

¶ Alterations don't create the dust, mess, and confusion involved in tearing down and rebuilding plaster walls.

¶ The cost of alteration is relatively low, since the salvage value of movable walls is nearly 100 per cent. And additional wall sections can be ordered as needed.

The double-panel movable partitions that carry electric wiring have another advantage, too. Electric outlets often must be added or changed in laboratory or equipment rooms. With sectional partitions, these changes can be made easily by taking down a wall section, rewiring, and replacing it. This saves breaking into a permanent wall.

In addition, most prefabricated walls are washable. They can easily be kept clean and hygienic.

Thus, where great flexibility in office arrangement is important, movable partitions are generally a fine thing. With them, moreover, you can make changes that you might postpone indefinitely with permanent construction. You can enlarge your treatment room or add an X-ray room by cutting down needless space elsewhere, perhaps in your consultation or reception rooms. The trick is simply to move the walls an appropriate distance (assuming that window locations permit).

On the other hand, for individual, one-man offices, architects who know medical-office design are less likely to recommend movable walls in preference to permanent construction. One argument involves money:

The initial cost of movable walls is higher than that of regular construction, sometimes considerably higher. Therefore, for infrequent minor changes, or for that once-in-a-doctor's-career remodeling job, prefabricated walls ordinarily won't pay off as an investment.

Also, because they are designed mainly for ease in remodeling inter-

announcing:

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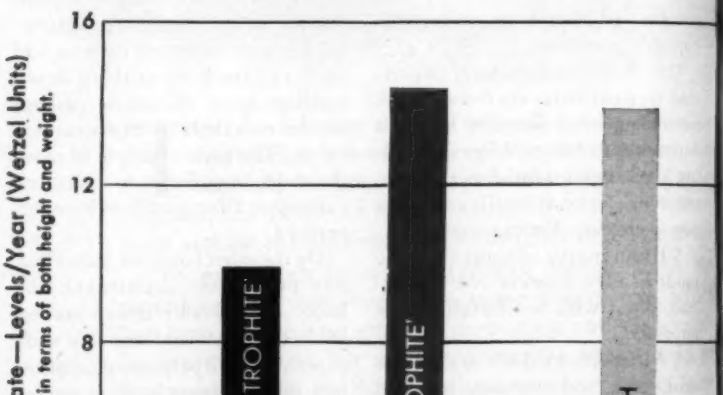
a delicious, high-potency elixir of B_{12} and B_1 to increapetit

See how 'Trophite' increases growth

In a controlled clinical trial—over a one-year period—'Trophite' produced almost a 50% increase in rate of growth in children who had been below par. (For details, see professional literature.)



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Formula
Each 5 c
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Dosage
One teas

Smith, K
*Trademark

ppetite and growth

'Trophite' increases appetite

When growing children lose appetite because of B_{12} or B_1 deficiency, 'Trophite' increases appetite by insuring adequate intake of both these factors.

'Trophite' is delicious

'Trophite' is not merely palatable; *it is delicious*. During the clinical trials, virtually every one of the hundreds of child patients expressed actual delight in taking 'Trophite'.

Formula

Each 5 cc. teaspoonful of 'Trophite' supplies Vitamin B_{12}, 25 mcg.; and Vitamin B_1, 10 mg. Available in 4 fl. oz. bottles—enough for 24 days' treatment at the recommended dosage.

Dosage

One teaspoonful daily—or as directed by the physician.

Smith, Kline & French Laboratories, Philadelphia

*Trademark

iors, many movable partitions have technical shortcomings when considered simply as walls for the average doctor's office. Here are some precautions to discuss with your architect before you decide to put them in:

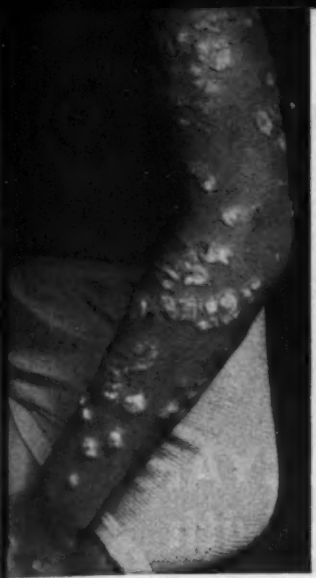
Soundproofing. Voices and noises, transmitted from room to room, can be a troublesome problem in a doctor's office. And according to architects, the sound-resistant quality of most movable partitions is often unsatisfactory. Hence, for consulting and treatment rooms you may want the thicker (more expensive) models. Or, in view of the expense, it may be wiser to settle for permanent walls.

Wiring and plumbing. Changing plumbing or electric outlets may present some problems when you rearrange your technical rooms. Movable partitions won't necessarily solve these puzzles unless you have the right kind. True, many of the more substantial (double) types of partition will take electric wires. But few will take plumbing pipes.

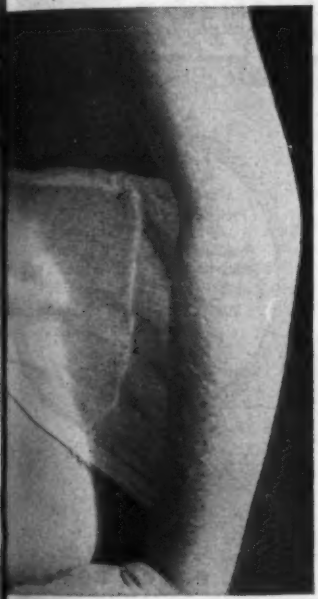
By keeping plumbing in the outside or permanent walls, or available through risers in the floor, you may be able to forestall such troubles. But they must be anticipated before building—with your architect's help.

Floors. To take full advantage of movable walls, two other points must be remembered when building: (a) These partitions support no structural weight; and (b) they rest on the floor, not in it.

So, if possible, your office should be laid out in a loft-type area—that is, four structural walls around a large, open space that can be divided into separate rooms by movable partitions. To avoid floor repair work in remodeling, the floor should



Before Use of Riasol



After Use of Riasol

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Psoriasis is believed by many to be a metabolic skin disease which responds most effectively to an *alterative.* Of all alteratives used in dermatology, *mercury* has the highest reputation.

RIASOL contains saponaceous mercury, that is chemically combined with soaps, in a carrier that penetrates the superficial layers of the epidermis. Hence the therapeutic agent reaches the deep epidermal layers where the lesions are located.

Deeper action explains the remarkable results obtained with RIASOL: namely, complete disappearance or great improvement in the skin lesions in 76% of all cases treated in a controlled clinical group.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

Ethically promoted RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.

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IASOL FOR PSORIASIS

For HYPERTENSION

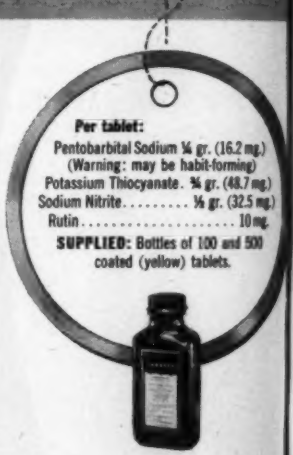
SAFER THIOCYANATE Therapy with

TURASED

TURASED provides rapid and prolonged reduction of blood pressure with lower serum levels of thiocyanate—thus increasing the margin of safety. Comparative clinical study[1] with TURASED has revealed "the infrequency of toxic or sensitivity reactions." In no case did capillary fragility become abnormal while the patient was receiving this preparation.

The potentiated, safer thiocyanate therapy made possible with TURASED is based upon the synergism offered by this original combination of ingredients.

1. Personnet, A. E., et al.: J. M. Soc. New Jersey 47: 504, 1950.



THE
E. L. PATCH COMPANY
STONEHAM • MASSACHUSETTS

be finished over the whole office area so that it runs under the partitions.

Even if you decide that movable partitions aren't feasible as a full-scale installation for your new office, you may find them handy solutions for minor problems. Often they're worth considering, for example, in these cases:

1. You need a small dressing room in the corner of your treatment room. To enclose it, an accordion-type, fabric partition may be what you're looking for. It can be mounted as a ceiling-high partition, for instance, in a semicircle around the dressing space.

2. Your secretary wants an enclosed office in or just off the reception room. For this enclosure, glass or part-glass movable partitions may do the trick.

3. Your outside entry or lobby opens directly into one end of the reception room and you'd like to fence it off. One of the translucent, corrugated glass partitions may accomplish this.

In spot situations like these, the aesthetic value often offsets the added expense. Moreover, sound proofing and plumbing problems aren't likely to be deciding factors.

In general, whenever you consider movable partitions, it's advisable to go into the subject carefully with an architect. Flexibility is an important consideration, but it has to be weighed against other needs that may be peculiar to your office set-up. END

"Hmm—Your mother makes you wash *your* hands *too*, huh?"

How to Get Known as a Dollar Chaser

Some things people say about certain M.D.'s and why they say them

● Man is the talking animal, and one of his favorite indoor sports is making gaseous generalizations—a lot of them directed at doctors. For instance, a bad experience with the rare physician who *does* put money ahead of medicine can lead to unqualified condemnations of the whole profession—like these voiced by two Decatur, Ill., citizens:

"They're just a bunch of grafters."

"Money is all they're interested in."

Seldom, of course, does the complaint take this rabid form. But A.M.A. interviewers who sounded out lay attitudes toward medicine among a cross-section of 300 families in Decatur, discovered that a lot of people are acutely conscious of the few money-grubbing M.D.'s. For example:

"There's need to instill in certain doctors a few ideals" . . . "If socialized medicine comes, the fault will lie in the doctors' own commercialism."

What do medical men do that gets some of them known as "dollar-chasers"? Here, based on the ad hoc criticisms of Decatur people, are several easy ways to give the profession this reputation:

Overcharge or fail to explain your charges. True, only 12 per cent of those questioned thought office and house call fees were too high in Decatur. Yet about three out of ten with opinions (and no doubt experience) considered surgical fees too high. A number of them said so in strong language: "Doctors won't unsheath a knife for less than $150" . . . "They usually add 30 per cent to what you expected" . . . "Poor people can't afford to have operations any more."

Is $150 too high for a tonsillectomy? Two people who had been charged that much felt they were rightfully indignant. Another told interviewers of a doctor who charged $75 "for setting a boy's cleanly broken arm—without X-rays." It was, he thought, "too much for twenty minutes' work."

Were there explanations for these charges? If so, the patients evidently hadn't heard them from the doctors.

Give the patient as little of your time as possible. Assembly-line procedures sometimes leave a patient

---

By James Fuller

With summer coming on

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- Hot weather increases incidence of allergic skin reactions and dermatoses with allergic components.
- Histar, presenting pyrilamine maleate, Merck, (2%) and a unique tar extract (5%) in a hydrophilic base, in the majority of patients produces rapid relief.
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Three years of clinical study have established the efficacy of Histar in

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On prescription, through all pharmacies, in 2 oz. jars. For dispensing, in 1 lb. jars through supply houses.

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You may send me literature and sample of Histar.

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ME

WHEN FOOD INTAKE *is inadequate*

When the patient's food intake is inadequate to supply essential nutrients in proper amounts, clinical experience has demonstrated the supportive value of a dietary supplement providing substantial quantities of virtually all needed nutrients—protein, vitamins, minerals, carbohydrate, and fat. The choice of the supplement prescribed, to a large extent, can determine the efficacy of the supplemented diet, since over-all nutrient adequacy is the primary aim.

It is apparent from the data shown below that Ovaltine in milk can serve well in markedly increasing the intake of virtually all known nutrients. Taken daily during periods of inadequate consumption of other foods, it offers an excellent means for preventing subclinical nutritional deficiencies which can undermine general health or retard recovery from illness.

The appealing flavor of Ovaltine makes it acceptable to children as well as adults, including the aged. Ovaltine in milk is easily digested, an important feature when digestive disturbances are a factor.

Patients have the choice of either Plain or Chocolate Flavored Ovaltine, both of which are similar in their wealth of nutrients.

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(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	260 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

wondering if he's received his money's worth. Said one: "You get two minutes' attention for four bucks."

Delegate too much work to office assistants. If delegating routine medical chores isn't done right, or if it's done to excess, it doesn't go down well with patients. In Decatur, one man complained that "office girls do 90 per cent of the doctor's work." When he got a bill ("Colon exams—$35 and $65") for work done by the doctor's assistant, he felt "really stung."

Charge extra for patients with insurance. Don't think that this practice escapes a patient's notice or censure, even if bilking the insurance company is admitted to be an old custom. Said one patient of doctors: "If they find you have insurance, they charge the limit."

Another cited his own example: The doctor said if *I* had to pay it, he would cut the bill; but if the insurance company paid, then it was $150. It didn't sound very good to have two prices."

Appear to favor well-heeled patients at the expense of the less fortunate. Several persons resented this kind of medical snobbery enough to speak up contemptuously: "Some doctors go off the deep end for more solvent patients and try to shove off the riffraff" . . . "People with lower incomes are made to feel inferior."

Spend your money too conspicuously. With many townspeople, respect for the doctor probably grows with increasing signs of his prosperity. But it's worth remembering that there are others, at least in Decatur, who say, "Until a doctor has a Cadillac, he's not satisfied." Or who notice a doctor who "was able to buy a farm after practicing here only 7 months."

Unfair? In greater or lesser degree, yes. But as the Decatur survey shows, some people *do* say these things, oftener perhaps than many doctors realize. And once in a while they are apparently justified in thinking that at least some doctors aren't in business for their patients' health. Said one cynic: "They're like everyone else—in it for the money they can get."

But not even his severest critic would contend that the doctor shouldn't use good business methods or that such methods, when properly applied, make him seem mercenary. The fact is, most laymen would agree with a Decaturite who remarked simply that

"The reason doctors make money is because they *work* like hell." END

"In future, Miss Low, when a patient rings, be a little prompter in answering!"

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ANTIBIOTIC
OINTMENT
FOR

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*Polycin**

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(Polymyxin B. Sulfate
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. . . a special diffusible base)

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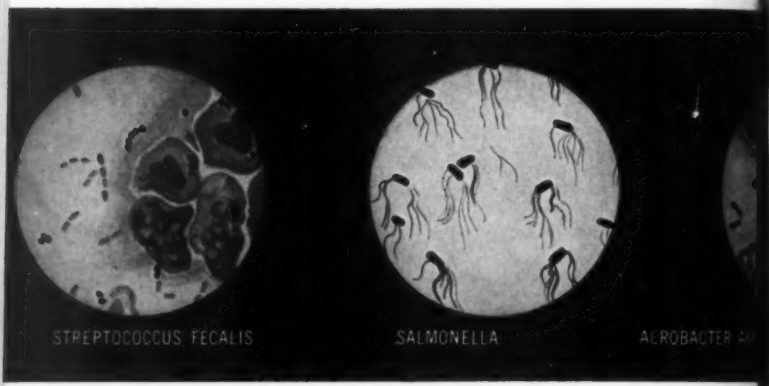
(b) **High diffusion to affected area**—Polycin is notable also for its unique base, Fuzene. This original combination of carbowax diesters and petrolatum allows maximal diffusion of the contained antibiotics to the site of the infection. Moreover its exceptional *spreading* property makes Polycin economical to use. Both polymyxin and bacitracin remain stable in Fuzene at ordinary temperatures.



Clinical Field—Typical indications[1,2] include: seborrhea; pyoderma; impetigo; sycosis barbae; folliculitis; and secondary infections of skin carcinomas, burns, eczemas, contact dermatitis, varicose ulcers, neurodermatitis, psoriasis and dermatophytoses.

Supplied in 15 Gm. collapsible tubes.

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1. Price, C. W., Randall, W. A., Welch, H., and Chandler, V. L.: Studies of the combined Action of Antibiotics and Sulfonamides, Amer. J. Public Health *39*:340 (1949).
2. Gastineau, F. M., and Florestano, H. J. L.: Clinical Experience with Polycin, A Polymyxin-Bacitracin Ointment. In Press.

He Reaps Rewards for Doctors

How one society hired an able executive—and got an A-1 public service program

• Until two years ago, Onondaga County doctors reflected the too-common symptoms of group lethargy. Their headquarters in Syracuse, N.Y., a city of 220,000 people, was a single two-by-four room. Their only employe, an office secretary, typed letters and answered occasional queries from such citizens as knew that the medical society existed. The doctors *did* have a commercially operated emergency-call service. But their organized public service activities stopped there.

Then things began to pop. One after another, public service projects took form. Today, Onondaga doctors maintain all the programs of an up-to-date society, and more besides. Along with eighteen lay employes in a large, modern office, the society now has:

1. A grievance committee.
2. A business bureau that collects delinquent accounts, supplies credit reports, and investigates hardship cases.
3. A round-the-clock telephone bureau that handles the emergency-call program and also provides a secretarial answering service for members.
4. A health information service.
5. A public relations program that includes such projects as press-radio dinners and a doctors' television show.

What's more, the doctors' new employes manage the business end of their monthly bulletin—once a chronic money loser, now a profitable enterprise. And they provide a good many courtesy services for individual physicians (even to getting them theatre tickets when they visit New York City).

How did Onondaga County's big transformation occur in such a short time? The answer is simple. The doctors hired a competent executive secretary and gave him the tools and a green light to go ahead with the job.

It was early in 1950 that the Onondaga society voted to modernize its organization. Back of this decision was a realization that the medical community wasn't keeping pace with the needs of the population. Sparked by industrial expansion, Syracuse had become the fastest growing city in the state. In a de-

By James C. Fuller

de, medical society membership
l jumped from 200 to 500. But
society itself was static, its poli-
pre-war.

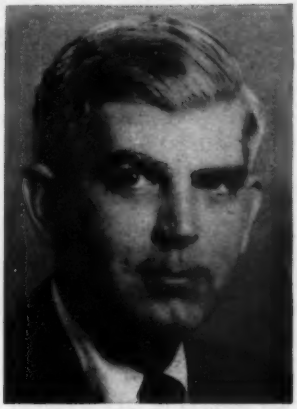
r advice, the doctors turned to
hen K. Leech, field man for the
York State society. Previously
d been a Manhattan manage-
consultant and sales manager
e Delaware Blue Cross.

Leech outlined a plan of action
them; and not only did the doc-
like the plan, they liked Leech.
they offered him the job of get-
g the new machinery running.

But a full-scale public relations
ogram doesn't come cheap, and
either do able executives. With
ly $14,000 in their till, the doctors
anted a big enough kitty to guar-
ntee the new program from the be-
nning. Instead of boosting dues,
owever, they voted a $100 assess-
ent to be levied on every member
ot only private practitioners but
sidents and local V.A. men as well.
is assessment is binding on all
ew members, too (until Septem-
ber, 1952), but they are given eight-
en months to pay.

Today, with the collection bureau
a self-supporting project and with
the telephone exchange approach-
ing a similar status, it's hoped that
the annual membership dues of $15
will remain static.

First return for the doctors on
their $100 investment was the griev-
ance committee. This was an-
nounced to the public in paid news-
paper advertisements two months



Stephen K. Leech
'More important than money'

after Executive Secretary Leech set up shop in April, 1950.

The Onondaga grievance committee has some unusual features. Unlike many others, for instance, it keeps the make-up of its committee (except the chairman) a secret. The reason, according to Leech:

Doctors Anonymous

"When grievance committee members are known, accused doctors have, in some instances, tried to put pressure on them. Also, when they know they're expected to keep their committee work sub rosa, they're less likely to talk to colleagues about the cases they hear."

Complete anonymity is, of course, impossible. But Leech claims that no more than 5 per cent of the mem-

bership know who is on the committee. Moreover, complainants rarely see more than one or two doctors on the grievance panel. And often their complaints are handled entirely through the executive secretary.

To date more than fifty grievance cases have been successfully disposed of. Of these, about 85 per cent were fee disputes; the others involved complaints about ethics and allegedly unsatisfactory treatment.

The Onondaga committee does not hesitate to take action in complaints against non-member physicians. For example, it threatened one local non-member with an opposing court action if he tried to sue for an unjust bill. The physician backed down. Another time, the committee asked a Manhattan specialist to reduce his bill substantially for a local resident who couldn't pay in full. The specialist did so without question.

"He's allergic to DDT."

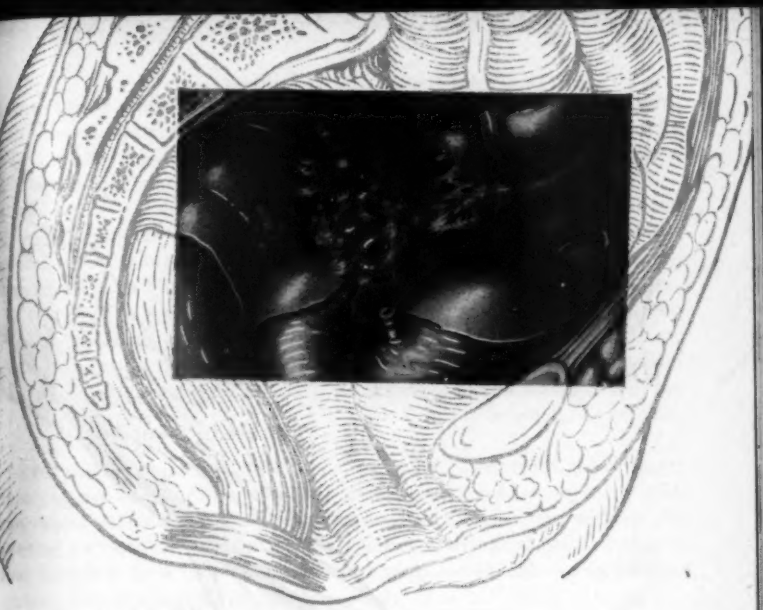
Because its services are so wel publicized locally, the society some times handles even non-medical hardship cases referred to it by lo cal citizens. Shortly after the busi ness bureau was announced, for ex ample, a Syracuse banker called Leech by phone. He had a woman in his office whom he thought the society could help.

The woman explained that her husband was a truck driver unable to work because of a recent accident and the onset of coronary trouble. Their three children had also been sick. Though she had gone to work, the family faced bankruptcy and the loss of their home. They owed nine teen commercial creditors, eight doctors, and one dentist—all press ing hard for payment.

First, the business bureau per suaded the physicians to reduce their bills. Then it got the coopera tion of the grocers, the milk and coal companies, and other creditors. By arrangement with the woman's employer, each creditor is now get ting a small monthly payment on his claim. Profit to the doctors: enor mous civic goodwill.

The collection bureau has also learned some lessons that it has been quick to pass on to members of the society. At first, says Leech, "the doctors gave us a lot of old dogs that other agencies had failed to collect." Now they listen more carefully to their executive secretary's advice:

"The best financial recovery is made on delinquent accounts from



pelvic inflammatory disease.....

pid response *with* Chloromycetin®

OROMYCETIN produces prompt clinical response in the
l infections commonly found in pelvic inflammatory
se. "In mixed infection [pelvic cellulitis and abscess]
OROMYCETIN appears to be superior to penicillin, strep-
cin or sulfadiazine."[1]

e clinical response to chloramphenicol consisted of
ed symptomatic improvement, usually within 48
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ses who had large pelvic abscesses were treated so
ively with chloramphenicol that posterior colpotomy,
drainage of the abscess, was not necessary in effecting
id cure in any of our patients who were treated with
nthetic from the start."[2]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is supplied in a variety of forms including:

CHLOROMYCETIN Kapseals®, 250 mg., **bottles of 16 and 100.**

CHLOROMYCETIN Capsules, 100 mg., **bottles of 25 and 100.**

CHLOROMYCETIN Capsules, 50 mg., **bottles of 25 and 100.**

CHLOROMYCETIN Ophthalmic Ointment, 1%, **¼-ounce collapsible tubes.**

CHLOROMYCETIN Ophthalmic, 25 mg. **dry powder for solution, individual vials with droppers.**

1. Greene, G. G.: Kentucky M. J. *50*:8, 1952.
2. Stevenson, C. S., et al.: Am. J. Obst. & Gynec. *61*:1086, 1951.

MEDICAMENTA VERA

Parke, Davis & Company

When patients kick at the idea of giving up coffee . . .

Medical drawing reproduced from "Gray's Anatomy" by permission of Lea & Febiger, publishers.

Tell him about grand-tasting Sanka Coffee. It's 97% caffein-free . . . can't cause sleeplessness or get on the nerves.

SANKA

The perfect coffee for the patient affected by caffein.

Products of General Foods

five to nine months old. The longer you keep non-paying accounts in your files, the less chance you have of getting your maximum dollar return."

By inducing the doctors to hew to this rule, the bureau—which collected less than $32,000 in its first year—expects to recover $75,000 to $100,000 this year. The society retains 40 per cent on bills under $20, one-third on those over $20.

Telephone Bureau

Last year, the doctors gave up their original emergency-call arrangement with the commercial answering service. To take its place, they installed their own telephone bureau, with the switchboard in the society's offices. Their aims were threefold:

¶ To assume full control of this vital public service by employing their own specially trained operators.

¶ To protect the public relations of members by assuring the best possible handling of emergency calls.

¶ To broaden the operation by including in it a telephone-answering secretarial service.

Because the success of a phone service depends so much on the operators' judgment, the doctors hire responsible women over 35. Under the supervision of the executive secretary, these operators get an intensive training course. They learn how doctors and hospitals work, and they acquire enough medical knowledge to question patients intelligently and pass the information on to physicians.

Emergency calls often demand quick decisions. One day recently, a husband telephoned to ask for instructions about delivering a baby. His wife apparently had never seen a doctor and was already in labor. The enterprising father planned to handle the matter himself. "But the baby seems to be stuck," he explained.

Catching her breath, the operator told him to hold everything. She quickly connected him with an obstetrician, who arranged an immediate ward service delivery for the patient.

The same operators also handle the doctors' secretarial answering needs. During the hours for which a doctor has arranged to have this service, a signal lights on the bureau switchboard when the phone rings

"It's just like a doctor's prescription."

first and **only**
topical therapy to contain
panthenol

CLINICALLY EFFECTIVE—
new studies[1,2] show that topical panthenol (analog of pantothenic acid) "favorably influenced the course of various ulcerative and pyogenic dermatoses. A majority healed and many showed various degrees of improvement." Even long standing conditions resistant to other therapy seem to respond to Panthoderm Cream which . . .
relieves pain and itching
promotes granulation and healing

"This preparation (Panthenol Cream) showed clinical evidence of *epithelizing stimulation*, of an *antipruritic effect*, and of an *antibacterial effect*... in a variety of dermatoses."[1]

Varicose ulcer of ankle, large, deep, profuse foul-smelling discharge.

Healing of ulcer after treatment with Panthoderm Cream for 10 weeks.

1. Kline, P. R., and Caldwell, A.: New York St. J. M., May 1, 1952.
2. Combes, F. C., and Zuckerman, R.: J. Invest. Dermat. 16:379, 1951.

in his office. Then the operator simply plugs in to take the call.

Syracuse doctors have found this most valuable at night and during other periods when their aides are busy in examination or treatment rooms. In fact, so useful has it proved that six months after it was set up the subscribers had doubled in number from forty to eighty.

Doctors on TV

The latest public service project of Onondaga doctors doesn't cost them a cent. It's a weekly television health show that they put on themselves.

Beamed at an afternoon housewife audience estimated at more than 40,000, this twenty-minute program features local pediatricians, obstetricians, dermatologists, public health nurses, and others. The doctors talk informally and answer questions about prenatal and child care. The nurses, using live babies, demonstrate the mechanics of carrying, diaper changing, etc.

To the local public, the doctors' big-time public relations program has meant a new awareness of, and respect for, their medical men. Says the editor of one Syracuse paper: "Prior to the advent of its new program, the local medical profession was thought of as a loosely organized body. As a result of its efforts over the past two years, the profession has become a potent force in the community."

The publisher of the other Syracuse paper, commenting on "the vast strides taken by the doctors to improve their public relations," adds: "After witnessing what has happened in England under the socialized set-up, we are more firmly convinced than ever that the sound system is along the lines demonstrated by our medical society."

To many an Onondaga County doctor, at first skeptical about the cost and necessity of the new policy, the results have been an eye-opener too. One elder statesman vociferously opposed the program before it went into effect. A year later, he telephoned Leech to apologize. "I was wrong," he said. "Now that I've seen it, I'm all for it. In fact, I've used most of the services myself."

Leech, who feels that any organization of 100 or more doctors can put at least one or more of these projects into operation, has this to say: "It's true that doctors can practice medicine adequately without any of these public services. But they can't do a rounded job for their community without them."

To do the community job effectively, as Onondaga experience illustrates, one thing may be even more important than money and enthusiasm. That is a trained, energetic executive who can set up a program and keep it going with a full head of steam. The best of these men have another talent, too. They know how to tell the public, from a *layman's* point of view, what the doctors are doing. END

STRENGTHEN

the will to recovery in patients depressed by pain

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		PER TABLET
provides effective analgesia	salicylamide . . . . . the *more potent, better tolerated* salicylate	250 mg.
elevates the mood	dl-desoxyephedrine hydrochloride . . . . . effective antidepressant and stimulant	1 mg.
improves the nutritional picture	thiamine hydrochloride . . . riboflavin . . . . . niacinamide . . . . . ascorbic acid . . . . . vitamins often depleted in anorexic, chronically ill patients	10 mg. 5 mg. 20 mg. 50 mg.

especially for chronic arthritis and rheumatoid disorders . . . convalescence from influenza and other debilitating infections . . . pain, depression, and anorexia in the aged

and as an adjunct in chronic, recurring headaches of nonorganic origin . . . dysmenorrhea associated with poor nutrition

For Hypertension

Mild Sedation...

Plus IODINE!
(organically bound)*

ORGAPHEN®

Elixir Organidin® and Phenobarbital

Iodine administered orally (as ORGANIDIN®)* has been shown experimentally to potentiate the hypnotic effect of phenobarbital. (Krantz, J. C., and Fassel, M. J.: J. A. Ph. A. *40*:511, 1941). This finding suggests that in treatment of hypertension concurrent administration of organically bound iodine

Means Less Phenobarbital For the Person "On Edge."

ORGAPHEN®, Wampole's unique elixir of organically bound iodine and phenobarbital, includes only 12 mg. (1/5 grain) of phenobarbital in each 4-cc. teaspoonful (the official elixir contains 20% more phenobarbital). Definite clinical potentiation of the phenobarbital sedation by the organically bound iodine has been observed following administration of ORGAPHEN, equivalent in effect to about twice the amount of phenobarbital alone. Thus relatively little phenobarbital produces adequate sedation when ORGAPHEN is administered. ORGAPHEN is supplied in pint bottles. *Samples and literature on request.*

**ORGANIDIN *provides iodine (2.5 Gm. per 100 cc.) organically combined with glycerin.*

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MANUFACTURING PHARMACISTS SINCE 187

Pros and Cons of Investing in

Convertible Preferred Stocks

Wisely chosen, they combine the good points of both preferred and common shares

• When a broker talks about an attractive convertible nowadays, he's less apt to mean something on the highway than on the stock exchange. For more and more companies issuing new preferred stock are giving buyers the right to trade it in—when and if they wish—for common stock.

Not that there's anything new in the idea. In any bull market that lasts long enough, convertibles come into favor. This is because, as the market goes higher and higher, many investors grow fearful of a crash—yet don't want to be left behind if prices go right on climbing. And the man who invests in a convertible preferred stock has these advantages:

¶ He enjoys the usual prerogatives of any preferred stockholder: (1) fixed-rate dividends ahead of any payments on the common shares, and (2) a superior claim to assets in case of liquidation. Thus, if the company's business goes into a funk, he can expect the price of his stock to hold up considerably better than that of the common.

¶ On the other hand, if the company's fortunes boom, sending its common shares kiting, he's in on the fun. An ordinary preferred stock would, under these circumstances, rise little if at all (being entitled only to the same old fixed-rate dividends). But a preferred that's convertible into a soaring common naturally does some soaring of its own. In fact, it rises right on the common's heels.

Suppose, for example, that you buy ten shares of Typical Manufacturing Company's newly issued convertible preferred. Assume that it's priced at $100 a share and pays yearly dividends of $3.50 a share. Also, that the conversion clause allows you to switch into common at any time, receiving five common shares for each share of preferred. The common, we'll say, is selling at $17; its current annual dividend rate is 50 cents a share.

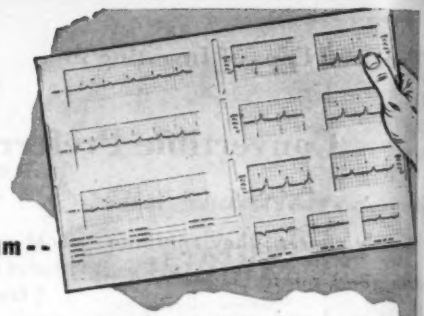
As long as the common remains under $20, your conversion privilege is largely of academic interest. It may cause some anticipatory gain

---

By Henry D. Steinmetz

*"the final authority" in cardiac arrhythmias**

--the electrocardiogram--



The electrocardiogram, the court of final appeal, is all-important in distinguishing the three most common forms of arrhythmia: sinus arrhythmia, premature systoles and auricular fibrillation.

THE Burdick EK-2

DIRECT-RECORDING ELECTROCARDIOGRAPH

— gives a clear, accurate and immediate record, automatically marked for timing and for leads. It is compact and portable, ready for instant use at your office or at the bedside. No photographic equipment required.

*The Med. Clin. of North American (Jan.) 1952, p. 93.

THE BURDICK CORPORATION
MILTON, WISCONSIN

in the price of your shares, especially as the common approaches the $20 line; but until that line is crossed, no tangible value attaches to convertibility.

But what happens if the common rises *above* $20? What if it hits $30 —or $40—or more?

As the common goes, so goes the convertible preferred—fivefold. That is, whatever the common sells for, the preferred will bring at least five times as much—since it is always exchangeable for five shares of common.

In actual practice, you probably wouldn't make the exchange. The only reasons for doing so would be:

1. If it would increase your dividend return;

2. If the preferred shares were called for redemption.

For instance, suppose things went so well for the company that it boosted its annual dividend payments on the common to $1 per share. Your ten shares of preferred would be paying you $35 a year. By converting them into fifty common shares, you could get $50 a year. What you'd have to consider, however, would be the risk of seeing the common dividend reduced or eliminated if the company came upon less palmy times.

For here's one thing to remember: Once you've converted from preferred to common there's no switching back; it's strictly a one-way street.

You might also decide to convert if the preferred issue were called for redemption. Most preferred stocks are callable, at the company's option, at par value or a few points above. Suppose your stock is callable at $105, but its market price has risen to $200 because of a rise in the common to $40. In the event of call, you'd obviously want to sell or to convert before the redemption date; otherwise you'd take a beating of $95 per share—the difference between market price (or conversion value) and call price.

What to Watch For

It's common practice for a company to call in convertible preferred stock under just such circumstances. The purpose is to force conversion, thus getting rid of a semi-fixed obligation (preferred dividends) or simplifying capital structure in preparation for the sale of new securities.

This raises some points worth bearing in mind:

¶ A convertible is quite apt to be a junior preferred issue, ranking behind one or more others. Also, it usually carries a lower dividend rate than would go with a conventional preferred of equal rank issued by the same company.

¶ Customarily there's a time limit on the conversion privilege, after which it either expires or the conversion ratio declines.

¶ To get the eat-your-cake-and-have-it-too feature (the stability of a preferred plus the appreciation possibilities of a common) you must

buy before the price of the preferred has been substantially inflated by a rise in the common. For the higher the preferred goes above its original level (where it sold chiefly on its own dividend and security merits), the farther it can fall if the price of the common collapses.

¶ The creation of a sizable convertible preferred issue may put a temporary damper on the market performance of the common. The prospect of future conversion, and consequent dilution of the common shares (each one of which would then have a smaller claim to earnings), may take the edge off an otherwise bullish picture—at least until the company's outlook becomes so bright that the common stock pushes upward in spite of everything. END

Sea Dog

• Back on dry land last month after almost a year and a half before the mast, Phillip M. Kauth, 70, could probably be excused for plying patients and colleagues in West Bend, Wis., with the high adventure of his 'round-the-world cruise on the square-rigger Yankee II.

A landlubber for all his previous years, the Wisconsin surgeon set sail in October, 1950, for what proved to be both a nautical education and a busman's holiday.

"Among the South Sea islands I was put to work whenever we hit port," he says, grinning through an authentic set of mariner's whiskers. "At Pitcairn Island I removed an appendix by lantern light, with eight crew members helping and most of

Dr. Phillip Kauth (right) shares the helm of the square-rigger Yankee II with cruise master Irving Johnson.

•

the native population kibitzing. At Takauroa, in the Cook group, one day, I pulled 156 teeth between breakfast and lunch."

Ready-Made Practice

News of the seagoing surgeon preceded him. So at every tropical anchorage he found plenty of broken bones to be set, tumors to be excised, and other emergencies to be dealt with. Often he was the first physician the islanders had seen in a year or more. Their standard media of payment: hospitality and sea shells.

Reported one of the Yankee II's crewmen: "If there was anything to be had on an island, the doctor got it. All the chiefs thought he was great and the kids followed him everywhere. He made a big hit with the gals, too."

Dr. Kauth bargained for neither medical work nor such popularity when, as a paying crew member, he signed aboard Skipper Irving Johnson's 120-foot brigantine out of Gloucester, Mass. Like the seventeen other crew members, he was seeking adventure. And he got it, as witness this entry from the doctor's personal log:

"Last night on my watch a bad storm hit us. It was so severe that the mate went to rouse the captain. We pitched fore and aft, rolled and tossed, with heavy rain and spray. While I stood watch, some of the younger men climbed aloft (over 60 feet) to shorten sail.

"As a doctor, I'm excused from deck duty whenever I want; but while the storm lasted I decided to keep myself available. It did not blow itself out until three days later; and, what with people getting seasick, rolling out of their bunks, and trying to keep from breaking their necks on deck, we had rather a rough time."

While Phillip Kauth gave treatment to the seasick, he doesn't say he was ever a victim himself. Yet there's one entry in his diary that seems to have been written with some feeling:

"To complicate matters, our dining table is hung on gimbals so that it is always level, no matter what the angle of the walls and floor. The food stays put nicely, but the effect

"First thing, we'll try to find out what makes you the obnoxious individual you are."

on a person who's the least bit nauseated is terrible."

Visits to island ports—from the West Indies to the South Pacific—were the highlights of the trip. Yankee II called at about 120 such ports—most of them little-known.

Snoozing and Cruising

After exploring his share of tropic atolls, Voyager Kauth wrote poetically of

A cruise without shoes
Wherever I choose
To just eat and snooze,
Minding no P's and Q's

And at an island near Haiti, he recorded this economic note: "We laid in a supply of fresh fruit: oranges, three for 1 cent; avocados, grapefruit, and other delectables, about 7 bushels for $5."

When at sea, each of the paying crew members stood two 4-hour watches every 24 hours. Dr. Kauth's favorite watch was the 8 to 12 (A.M. and P.M.). Reason:

"Then you don't have to scrub the deck; and while they keep you busy during the morning watch, you have time to contemplate during the evening watch. And one has practically all day for reading and photography."

When not swabbing the deck, painting, or polishing during watches, crew members were often busy making "baggy wrinkles." These Dr. Kauth describes as "short pieces of rope woven into long, thick, fluffy strands" that are wound around the rigging in certain spots to keep the sails from chafing.

Between watches, crew members' time was their own. Many of them spent a part of each day writing. "There are usually six to eight typewriters going full-tilt in the main cabin below deck," wrote Sailor Kauth.

Once a week the doctor lectured to the crew. ("I love to talk," he says.) Topics ranged from cancer to the Gay Nineties.

In all, Seaman Kauth found his globe-girdling journey a marvelous tonic. Toward the end of his log is this conclusion:

"I have figured that a trip like this for all you older colleagues would probably lower your blood pressure, cure your ulcers, and give you an entirely new sense of values." END

"What have you got that'll give me heartburn immediately, instead of at 3 o'clock in the morning?"

Pyribenzamine —antihistaminic action* to relieve conge
+
Nupercaine —local anesthetic action for prompt a
tion, inflammation and pruritus
prolonged relief of pain.

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SUPPOSITORIE

*Loew, E. R.: Physiol. Rev. 27:542, 1947.
Haley, T. J., and Harris, D. H.: J. Pharm. & Exp. Therap. 95:293, 1949.

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Also available as Tricainal Rectal
Ointment in 1 oz. tubes.

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PYRIBENZAMINE® (tripelennamine)

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G.E. Pioneers Catastrophic Coverage

What an enterprising group of employes learned about licking big medical bills

• To explain the halting development of medical catastrophe insurance, spokesmen for insurance companies and the doctors' plans alike have pleaded lack of experience. Fortunately, though, some people aren't afraid to pioneer.

Back in 1947, some 2,500 General Electric employes (largely executive and professional) decided that they wanted protection against abnormally large medical bills. It took two years of hard planning and a lot of old-fashioned Yankee initiative, but they finally succeeded in setting up a group plan that they say was the first of its kind in the country.

Their successful venture has yielded benefits not written into the insurance contract. For one thing, it has helped stimulate commercial companies to go ahead with medical disaster programs. For another, G.E.'s experience has shed light on problems that have plagued insurance planners in this field for years.

At first the G.E. group made discouragingly slow progress in putting over their insurance dream. One after another, the commercial underwriters turned down the project. Not enough statistics to base the plan on, they said. Or too expensive; or this kind of protection would send medical costs skyrocketing. In 1949, at last, Liberty Mutual agreed to underwrite the plan.

G.E.'s catastrophic coverage program has now been in full operation for more than three years. It has paid out upwards of $260,000 for major medical expenses. It has proved the idea both workable and reasonably inexpensive.

The scientists, engineers, and managers who took the first leap in the dark were an ideal group for the experiment, according to E. S. Willis, manager of G.E.'s Employee Benefit Plans Department. Large enough to get a good spread of risk, this group included men over 35 (average age about 50), with incomes above $7,000 a year. They could afford relatively expensive premiums.

At first, they paid $3 a month. For this, the plan guaranteed 75 per cent of medical and hospital expenses up to $3,000 (but limited to $1,500 in a single year) for any one disability. The plan has a deductible provision

By James C. Fuller

a fresh and vigorous improvement

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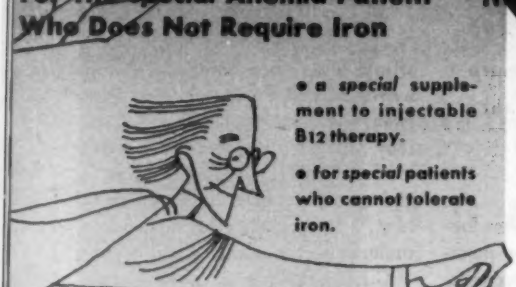
activated

For the *Special* Anemia Patient Who Does Not Require Iron



- a *special* supplement to injectable B12 therapy.
- for *special* patients who cannot tolerate iron.

Each ARMATINIC SPECIAL Capsulette contains:

*Crystamin	10 mcg.
Folic Acid	1 mg.
Ascorbic Acid (Vitamin C)	50 mg.
**Liver Fraction II (N.F.) with Desiccated Duodenum	350 mg.

*The Armour Laboratories Brand of Crystalline B12.

**The liver is partially digested with an equal quantity of duodenum during manufacture.

Supplied: Bottles of 100.

for the management of certain macrocytic and the microcytic anemias

- **effective potencies of the hemopoietic factors needed to assure a rapid and complete response in these anemias with a minimum of therapeutic failures.**

ARMATINIC SPECIAL and ARMATINIC ACTIVATED Capsulettes both supply B12 *plus activator*, the intrinsic factor to potentiate the effect of orally administered vitamin B12. Also available ARMATINIC LIQUID, the new hematinic with Crystalline B12 and Clarified Liver, in 8 oz. and 16 oz. bottles.

Each ARMATINIC ACTIVATED Capsulette contains:

Ferrous Sulfate, Exsiccated	200 mg.
*Crystamin	10 mcg.
Folic Acid	1 mg.
Ascorbic Acid (Vitamin C)	50 mg.
**Liver Fraction II (N.F.) with Desiccated Duodenum	350 mg.

*The Armour Laboratories Brand of Crystalline B12.

**The liver is partially digested with an equal quantity of duodenum during manufacture.

Supplied: Bottles of 100 and 1000.

THE ARMOUR LABORATORIES CHICAGO 11, ILLINOIS

world-wide dependability

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

and does not pay the first $300 in medical bills; but for most members this is covered anyway by other health insurance.

By the end of the first year, the plan was ahead of the game. So the premium was cut to $2.25. For another $3 a month, employe-members were then allowed to insure their wives and children.

A year later, the plan was still ahead. So, with no hike in premiums, the maximum benefit was raised to $5,000 without a time limit. In addition, company pensioners (over 65) were permitted to keep their coverage after retirement.

What Catastrophes Cost

With a cross-section of both sexes, young and old, to learn from, G.E. has come up with tentative answers to such questions as: What is the average cost of serious illnesses? Who is most likely to get expensively sick? Which diseases most frequently run up big bills?

Since the plan began, the average total cost per catastrophic illness for an individual male claimant has been $1,119; for a wife, $962; for a child, $606. Only about 10 per cent of the individual budget-busting disabilities have cost more than $2,000. And, as might be expected, the average claim of a male pensioner over 65 is nearly double that of the middle-aged, active employe.

With what frequency does expensive sickness hit? G.E. has found that 2 to 3 per cent of the male members have put in claims annually. Their wives, however, get expensively ill (or pregnant) somewhat more often. In a typical year (1950), for example, there were 193 claims among the nearly 2,500 families:

Employes	73
Wives	103
Children	17

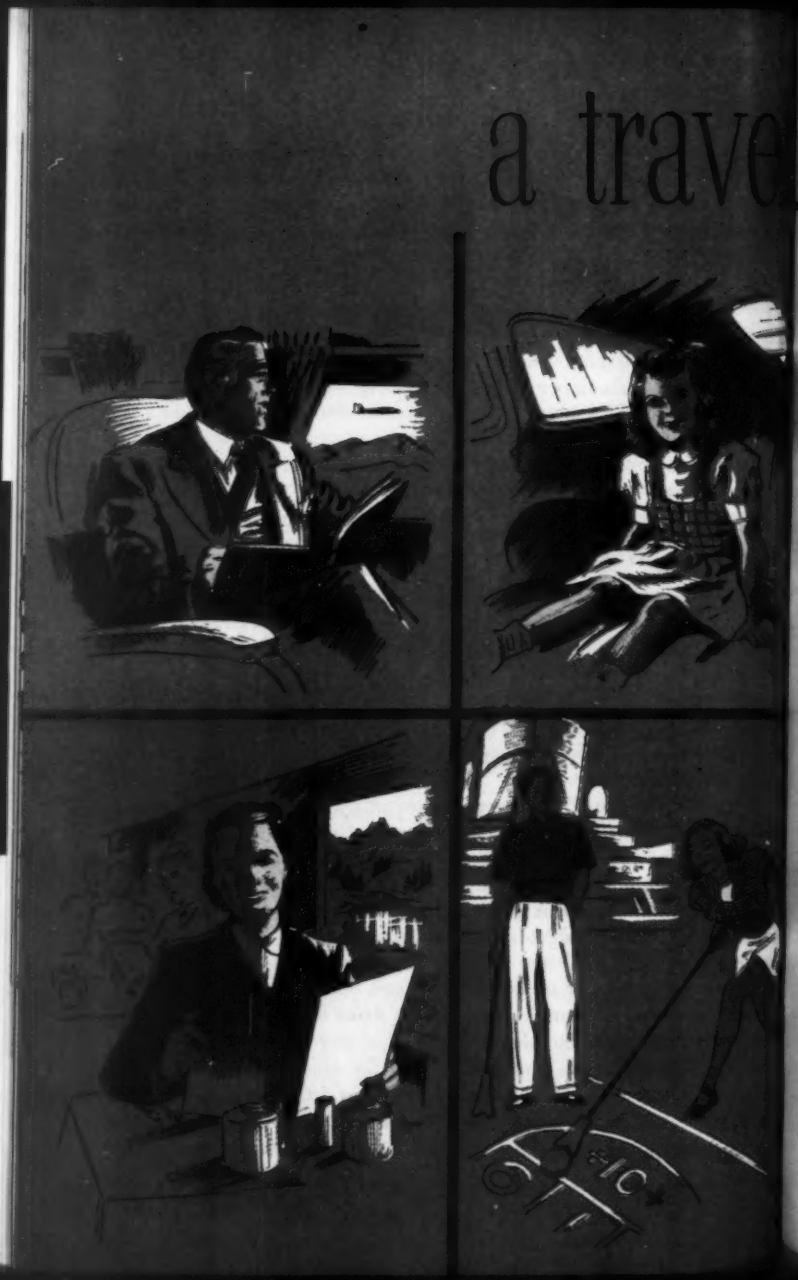
Hernia and Hemorrhoids

Among the men, the disabilities that most often lead to big bills arise from heart and circulatory ailments, genito-urinary disorders, and hernia. For their wives, the G.E. plan pays off most frequently in female disorders, pregnancy, nervous and mental diseases, and gastro-intestinal troubles. But even hemorrhoids, G.E. has found, can frequently run medical bills up over the $300 mark.

So, gradually, the facts are being marshaled, the statistics piled up. Plenty of problems remain, of course. For instance, G.E. experience has so far not evolved a wholly satisfactory yardstick for measuring the extent of a *single* disability.

When one man had duodenal ulcer followed by cerebral thrombosis, they were classed as separate disabilities. So the $300 deductible clause applied to each illness. But in cases where possibly related diseases strike in quick succession, the decision may not be easy.

On the other hand, when a subscriber has disabling recurrences of the same sickness, the G.E. plan now permits the $5,000 maximum to ap-



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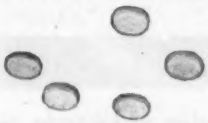


The pleasure of summer travel often is spoiled by the nausea and vomiting which result from train, car, plane, ship or bus trips.

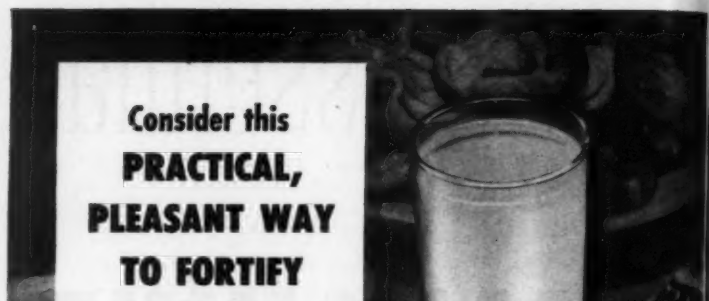
Dramamine, tested repeatedly on various means of transportation, offers susceptible persons a substantial assurance of symptom-free travel.

Dramamine is effective in the prophylactic as well as the symptomatic treatment of motion sickness.

TABLETS—50 mg. **LIQUID**—12.5 mg. per 4 cc.
(AVERAGE ADULT DOSE—50 mg.)

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE



The inclusion of Vitamin A-D fortified skim (or partially defatted) milk in low-fat high-protein diets has been found highly beneficial in all these cases . . .

☑ **INFANT FEEDING**—superior weight gains, improved appetite where apathetic to regular milk, apparent better utilization of Vitamins A & D in aqueous form.

☑ **PREGNANCY & LACTATION**—an even richer protein source than whole milk—enhances resistance to edema, toxemia, anemia, hypertension.

☑ **GERIATRICS**—increased vitamin, calcium & protein requirements, limited fat intake—are ideally met.

☑ **POOR FAT TOLERANCE**—enhanced assimilation of fat-soluble Vitamins A & D in various disorders.

☑ **OVERWEIGHT**—a nutritious, appetizing base for low-calorie diets—assures needed protein, mineral & vitamin intake.

VITEX LABORATORIES SUPPLIES THE DAIRY INDUSTRY WITH THESE QUALITY PRODUCTS

- **VITEX® A-D**—a concentrate of natural Vitamins A & D in non-fat milk solids. 2000 "A" and 400 "D" units (USP) per quart.
- **VITEX NATURAL "D" AND BVO® IRRADIATED ERGOSTEROL** — for quality Vitamin D Homogenized Whole Milk.
- **"MULTI-MIX"***—new multiple vitamin-mineral concentrate.

*Trade Mark Nopco Chemical Co.

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A DIVISION OF NOPCO, HARRISON 5, N. J.

Pioneer Producers of Vitamin Concentrates for the Dairy Industry

NOPCO

ply to that illness, whatever its duration, and deducts the first $300 only once. Such expenses on a continuing basis, notes Mr. Willis, may be "as much a catastrophe as high costs concentrated in a short period."

Lower-Income Groups

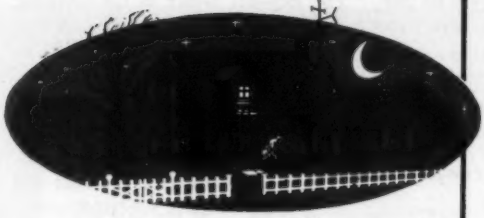
To one very important question, G.E. has found an answer. The question: Can catastrophic coverage be adapted to lower-income groups? The answer: yes.

For well over a year now, about 27,000 G.E. employees in Schenectady, N.Y., have had their own form of medical disaster insurance. The benefits aren't as far-reaching as those in the original executive plan—for one thing, these employes can't as yet insure their dependents—but the rates are attractively low.

Though these plans have taken a long step into an uncharted field, G.E. officials emphasize that still more experience is needed before they will shake down into final form. But the pioneer work has been done; and the company has good reason for its hope that the results may help others "as they consider means of providing catastrophic coverage on a basis for free exercise of private initiative." END

"No, they didn't help me much at the clinic. By the time I'd paid for their diagnoses, I hadn't a cent left for treatment."

When the patient



. . . sleeps poorly

. . . doesn't eat well

. . . is "always tired"

Restoration of a normal emotional picture is often facilitated by including BĒPLETE in the therapeutic regimen.

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Vitamin B-Complex with Phenobarbital Wyeth

A judicious combination of low dosage sedation and high dosage vitamin B therapy, including vitamin B_{12}.

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Are Doctors Poor Givers?

Professional fund raiser finds M.D.'s above average in contributing hard cash

By George Radcliffe*

• The fact is—doctors are generous. This simple and heartening revelation will come as a surprise to a considerable body of laymen who for years have claimed that doctors as a group are the worst givers to fund-raising campaigns, and even poor supporters of fund appeals for the very hospitals to which they are attached.

Quite the reverse is true.

Figures on more than 1,000 hospital campaigns in 245 U.S. cities in the last 33 years reveal that the highest per capita contributions to these institutions came from the physicians on their staffs. Take any group of businessmen—florists, grocers, dry cleaners, hotel operators, or what you will—and you find no comparison in the size of giving.

A recent survey (see table on page 145) of six major hospital campaigns confirms this. It shows that $928,661 was contributed by only 601 doctors. In analyzing these six appeals (for a combined goal that totaled more than $5 million) it was found that doctors had contributed almost 18 per cent of the total.

The average gift, as shown in the table, was $1,545—a tidy sum any way you look at it.

Another example of big giving by doctors is the medical staff fund-raising campaign now under way at Jefferson Medical College and Hospital in Philadelphia—the largest such campaign I know of. Jefferson has 456 men on its staff and faculty. Of these, about 100 earn salaries of $5,000 or less in the pre-clinical departments, and another 100 have only thin ties with the institution.

Yet this staff and faculty accepted a quota of 15 per cent of a $4,500,000 goal for a hospital addition—and they are raising it!

When the staff first accepted its own quota of $675,000 under the leadership of Thomas A. Shallow, professor of surgery at Jefferson,

---

**The author is senior campaign director of Ketchum, Inc., Pittsburgh. He has, for twenty years, served hospitals across the nation as a professional director of fund-raising drives. This article is being published simultaneously in* MEDICAL ECONOMICS *and The Modern Hospital.*

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INTERNATIONAL BUSINESS MACHINES

there were more who scoffed than cheered the effort. But within a month, Dr. Shallow and his assistants had classified the entire staff, built an organization, solicited 83 per cent of their men, and raised $545,000, or an average of $1,442 per staffer. And they're still going.

The financial problems faced by today's doctor are often overlooked by those prone to criticize the physician's giving record. Many volunteer workers on hospital campaigns have loudly condemned the doctors who have "not given enough" to support what laymen consider to be the doctor's "workshop."

True, some doctors do not give adequately to vital community causes. But the same can be said of some businessmen.

In the doctor's case, however, the public has developed the attitude that all physicians are wealthy and should, therefore, be in the vanguard of fund-raising campaigns. An economic study of the American physician shows that his *net* income is less than the public believes. There are some topflight men, of course, who earn sizable incomes. Some surgeons, for instance, net $100,000 or more a year. But for every one in this bracket, there are

Doctor Participation in Six Recent Hospital Campaigns

Hospital	Goal of Fund Drive	Total Donated by Doctors	Doctors' Share of Goal	Number of Doctors Donating	Average Donated by Doctors
Aultman Canton, Ohio	$1,097,855	$196,710	17.9%	165	$1,192
Hackensack Hackensack, N.J.	1,750,000	267,245	15.2	150	1,781
St. Luke's Kansas City, Mo.	1,000,000	202,616	20.2	125	1,620
Mercy Muskegan, Mich.	450,000	123,160	27.3	73	1,687
Newark City Newark, Ohio	400,000	60,600	15.1	39	1,553
Sewickley Valley Sewickley, Pa.	550,000	78,330	14.2	49	1,598
Recapitulation	$5,247,855	$928,661	17.7	601	$1,545

ESTIVIN®

Relieves Eyes *Swimming* in Tears of Distress

"Can't see" weeds are flooding pollen into swollen eyes.

ESTIVIN relieves ocular and nasal discomfort caused by hay fever. General conjunctivitis is also readily alleviated with ESTIVIN.

ESTIVIN is an aqueous infusion of "rosa gallica L." It is decongestive and soothing to irritated ocular and nasal membranes.

Dosage:

One drop of ESTIVIN in each eye will alleviate ocular and nasal discomfort and inhibit the production of irritating fluids.

Supplied: 0.25 fl. oz. bottle and dropper

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hundreds with modest incomes. In 1949, the Department of Commerce reports, while non-salaried U.S. physicians averaged almost $12,000 net, a third of them netted less than $7,000, a quarter netted less than $5,000.

Nor is the public fully aware of the other factors affecting the doctor's ability to give. While in the case of a business concern, everyone realizes that its gross volume does not represent the net income of the owner, people are inclined to overlook completely the hefty operating expenses of the doctor.

There's also the factor of the time and money spent on his education, which is equivalent to the capital investment in a business. And according to all tenets of good business, this investment must earn a fair return before a true net profit can be shown.

Finally, the M.D. suffers more from poor-paying clients than does almost any other business or professional man. He is often the first to be called and the last to be paid—if, indeed, he is paid at all. He devotes a great deal of time to out-and-out charity cases (especially if he is on the staff of a hospital) and he frequently comes to the aid of anonymous accident victims. It has even been argued that in terms of time and skill he donates so much to the community that it is unfair to count on *any* cash contributions from him.

Despite these factors, doctors have given a spectacular demonstration of their generosity in hospital campaigns. In this they seem to agree with other Americans who feel that hospitals must be kept from state control and that the only way to do it is to make certain they are adequately financed through the free contributions of free people. END

Dead End

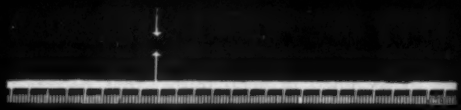
• "Dear Dr. Smith," the letter ran, "In my two weeks at the hospital, I must have seen almost every specialist and had almost every test. But I'm wondering now if it wouldn't do me some good to be sent to Dr. King's clinic, which was held so often while I was at the hospital. Do you think this would help me?"

Dr. Smith hastily dispatched a letter saying he didn't think it would help. (Our pathology department uses the loudspeaker announcement, "Dr. King's clinic is now in session," to let staff physicians know whenever an autopsy is about to be performed.)

—LESTER S. KING, M.D.

Isatin

For centuries prunes have been Nature's own laxative food. A Harrower research team recently discovered that besides their emollient and colloidal properties, prunes contain an additional gentle peristaltic stimulant. This laxative principle is called ISATIN.



Kymograph tracing showing gentle increase in peristaltic waves produced by ISATIN.

HARROWER

combines ISATIN with a prune concentrate and methylcellulose to provide activated moist bulk for the treatment of functional constipation.

PRULOSE COMPLEX provides the essential gentle activation of peristalsis without any undesirable side effects.

PRULOSE COMPLEX is available in both tablet and the new liquid form.

DOSAGE 1 or 2 tablespoonfuls of liquid, or 3 or more tablets, with a full glass of water, twice daily, preferably after breakfast and before retiring, until normal elimination is established. The dosage may then be reduced.

SERVING THE PROFESSION IN A PROFESSIONAL MANNER

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etters to a Doctor's Secretary

e'll be more efficient—
l less harried—if she
ps out a daily routine

Dear Mary:

Your last letter sounds as if you e discouraged—violently so. I like r violence. It can work miracles en properly directed.

You say you get along well in the rnings and that you have the rical work well in hand; but, oh, afternoons! When you have to lp the doctor in the examining m and act as nurse and secretary the same time, it just about drives crazy. You say you simply can't in three places at once; that in daily schedule I gave you I al- d no time for making dressings, king laundry, sterilizing, and a n other things you must do be- d the scenes.

Your complaint is justified. But I n to assure you that the case is from hopeless.

The things you mention constitute the mechanical end of your work. They require, in the main, only manual dexterity. As soon as you become efficient in handling them and can standardize your procedure, these little jobs will almost do themselves.

Let's break down the typical afternoon's "frenzied hodgepodge," as you call it, into a list of the separate things that go to make it up. In addition to the secretarial and reception-room duties previously discussed, there are these:

1. Preparing women patients for examination, and assisting the doctor during examination.

2. Cleaning up the examining room after each patient, and cleaning up the laboratory after the doctor has finished working there.

3. Sterilizing gloves, instruments, and dressings.

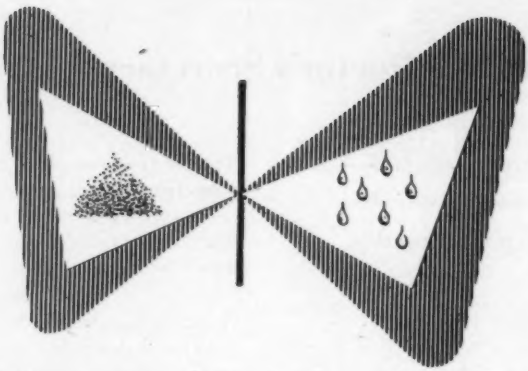
4. Making dressings, swabs, and cotton pledgets.

5. Checking and ordering supplies and laundry.

That's quite a list, considering the

By Anna Davis Hunt

These letters were published originally as a series in MEDICAL ECONOMICS, *signed with the nom de plume, Myrna Chase. In response to many requests, they are now being reprinted in a revised and updated form. The complete current series, of which the present letter is the eighth, will also be made available as a portfolio.*



"Little drops of water
Little grains of sand ..."

All too often the "little things" are overlooked or disregarded. Take the choice of soap in the management of a dermatological condition, for example. Years ago physicians paid little attention to the particular soap a patient was using, but since that day it has been shown that an irritating soap can further aggravate an already inflamed skin and actually retard healing.

Today more and more physicians prescribe pure, mild, nonirritating **MAZON** Soap to cleanse the skin and prepare it for medication with antiseptic, antipruritic, antiparasitic **MAZON** Ointment. This dual therapy is used with marked effectiveness in many cases of acute and chronic psoriasis, eczema, alopecia, ringworm, athlete's foot, and other skin conditions not caused by or associated with metabolic disturbances.

MAZON is greaseless . . . requires no bandaging; apply just enough to be rubbed in, leaving none on the skin.

MAZON

At all pharmacies

BELMONT LABORATORIES Philadelphia, Pa.

fact that you're supposed to be in the reception room most of the time and that the telephone usually rings all afternoon. But it's really not so bad as it sounds. It means that you have to increase your tempo, but it need not spoil the rhythm.

The whole thing is really a matter of harmony, which my dictionary calls "a just adaptation of parts to each other, giving a pleasing whole." Note especially the word "just." If you make up your mind not to give a second more to any task than it justly deserves, things will seldom pile up. I don't need to add that this harmony must exist in your mind before it can exist in your actions.

I think perhaps you've been trying *too* hard and rushing *too* much. Let's get down to cases and examine in order the five duties listed above.

Preparing the Patient

Office hours have begun. A long list of appointments stretches ahead of you. Dr. Barrie has taken the history of Mrs. Smith, a new patient, and has rung for you to get her ready for a complete examination.

You usher her immediately into the examining room. You don't stop to chat with her; but your manner is pleasant and interested, with no appearance of hurry. You give her the necessary directions in a firm, clear voice, with not a syllable wasted, so she'll know exactly what to do. Have a regular formula so that even the slight effort of thinking about what to say is unnecessary. For instance:

"Please remove all your clothes, except your slip and shoes and stockings. I'll be right back."

Then leave the room.

This routine is so old a story to office nurses that some of them form the lamentable habit of giving directions hurriedly and vaguely, taking it for granted that the patient will know what to do. Naturally, the nurse is annoyed when she comes back in a few minutes and finds the poor woman sitting on the edge of a chair, flushed and nervous, with most of her clothes still on. But it isn't entirely the patient's fault.

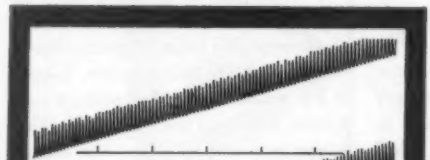
So be sure to tell the patient exactly what to do. And don't forget the "I'll be right back." It speeds her up and reassures her at the same time.

When you leave her, you slip back into the reception room, greet anyone who has arrived in your absence, and usher the next patient into the consulting room, where the doctor can keep busy until you call him.

The Examination

You then return to the examining room and find Mrs. Smith awaiting you in the correct state of semi-nudity. You assist her into position on the examining table and drape her with a fresh white sheet. From a drawer in the examining table you take all necessary instruments and lay them in a row on the side table. You buzz for the doctor and stand by while he proceeds with the examination. [MORE→

Announcing a New and Specific Narcotic Antagonist —



potent and well-tolerated

Effect of NALLINE *on respiratory depression caused by 57 milligrams of morphine.*[1]

NALLINE is a specific antidote for poisoning following accidental overdosage with morphine and its derivatives, as well as meperidine and methadone.

This new product, the Merck brand of *N*-Allylnormorphine, rapidly reverses respiratory depression. The respiratory minute volume promptly increases and the rate increases two- or threefold.

A recent study[2] of 270 parturient women indicates that NALLINE may be of value in obstetrics. Onset of breathing occurred significantly sooner in infants from mothers (sedated with meperidine) who were given NALLINE 10 minutes prior to delivery. *Literature available.*

[1]Eckenhoff, J. E., Elder, J. D., and King, B. D., *Am. J. Med. Scs.* 223:191, February 1952. [2]Eckenhoff, J. E., Hoffman, G. L., and Dripps, R. D., Annual Meeting of the American Society of Anesthesiologists, Washington, D. C., Nov. 8, 1951.

SUPPLIED:
Solution of NALLINE Hydrochloride in 2-cc. ampuls containing 10 mg. of active ingredient, 5 mg./cc.

NALLINE comes within the scope of the Federal Narcotics Law.

NALLINE

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(*N*-ALLYLNORMORPHINE HYDROCHLORIDE, MERCK)

Research and Production for the Nation's Health

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Manufacturing Chemists
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Always carry a small pad of paper and a pencil in the pocket of your uniform, for Dr. Barrie likes to dictate his findings as he examines (with the obvious exception of anything that might alarm the patient).

No Time to Lose

If, during the examination, someone enters the reception room or the telephone rings, step out quickly and attend to it, leaving the door slightly ajar behind you. The idea is that the doctor shall never be left alone with a disrobed patient. The better type of woman prefers it; and in the case of the other type it is occasionally a real protection to the doctor. At all events, get back to him as soon as possible.

As the doctor finishes with his gloves and instruments, he lays them on a paper towel that you have placed on the instrument tray. The examination over, he returns to the consulting room.

Meanwhile you help Mrs. Smith from the table, telling her (again, clearly and distinctly): "You may dress now. Dr. Barrie will return and talk to you in a few minutes. Just wait for him here."

This will prevent her popping her head out of the door or wandering vaguely about after she is dressed. And it is clearly better form for Dr. Barrie to talk over his findings with her after she is dressed than while she is still on the table.

Your next step is to pick up the instruments and gloves in the paper towel on which they were laid. Then gather up the sheets that covered the examining table and the patient, and walk (don't run) to the surgery. Put the sheets in the laundry closet; rinse off the gloves and instruments and place them in the sterilizer (which is kept boiling all afternoon); take a short turn through the reception room; and return to the patient.

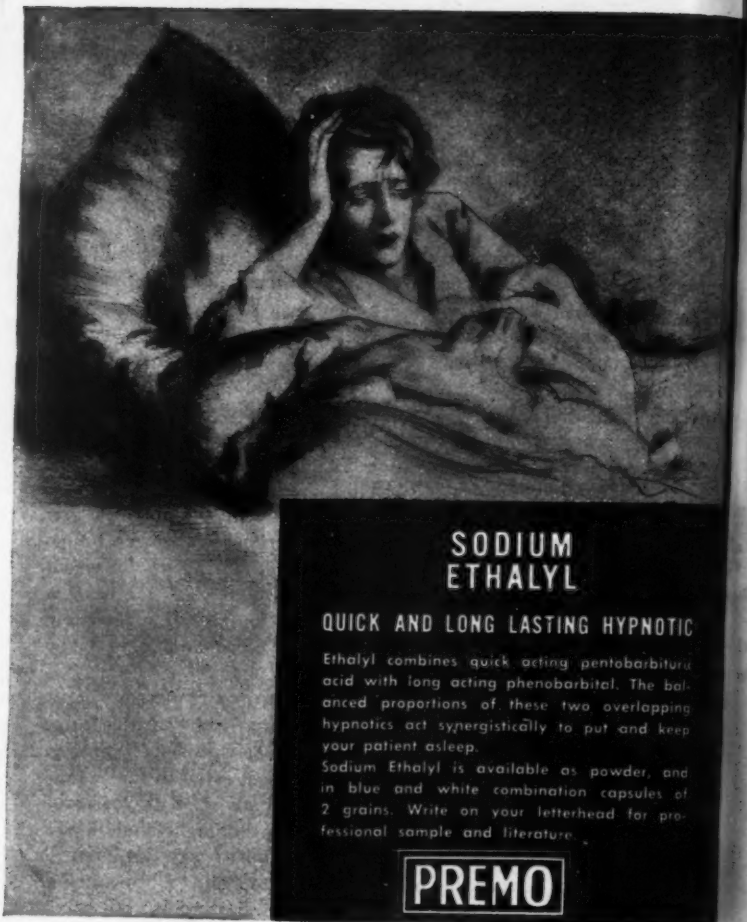
As she is putting on her hat, you take a clean sheet from the cabinet and cover the table with it. (Done in the patient's presence, this has good psychological effect.) You then buzz for Dr. Barrie, who comes to finish the interview.

If the patient he left in the consulting room is ready to be examined, you take her to the second examining room, usher the next patient from the reception room into the private office, and begin the cycle all over again.

Next time you return from the surgery, bring with you the instruments that have just been sterilized and put them away in the examining-table drawer. Rubber gloves have to dry thoroughly and be powdered, so don't try to use them the same day they have been boiled. Keep a plentiful supply on hand.

Like a Symphony

Can you sense the rhythm in this procedure? If you like music, it's fun to think of the afternoon as a symphony. Don't get tense. Breathe deeply. Try to make all your move-



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QUICK AND LONG LASTING HYPNOTIC

Ethalyl combines quick acting pentobarbituric acid with long acting phenobarbital. The balanced proportions of these two overlapping hypnotics act synergistically to put and keep your patient asleep.

Sodium Ethalyl is available as powder, and in blue and white combination capsules of 2 grains. Write on your letterhead for professional sample and literature.

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FREE Physicians' sample of the new Premo specialty.

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Please rush me sample of your new product — Sodium Ethalyl.

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City _____ (E)

ments graceful and exact, never jerky or abrupt.

Dr. Carl does most of the laboratory work; and I'll admit the place looks as if a cyclone had struck it when he gets through. But any girl who has ever washed the dinner dishes at home will find it easy to clean up after him in less than five minutes.

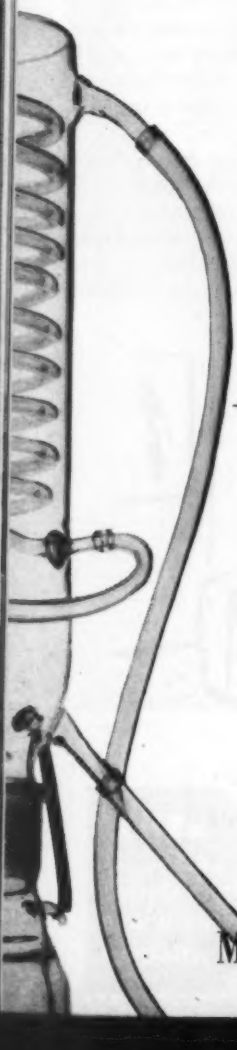
Two or three times during the afternoon, look into the laboratory and do whatever is necessary. Repeat this just before you go home.

Some day when you're not very busy or when Dr. Barrie is away, ask Dr. Carl to teach you how to do blood counts and urinalyses. You'll find it so fascinating that you'll never again mind washing a test tube. It will make you more valuable, too.

I've said that you must spend as much of the afternoon as possible in the reception room. And that's so. You will really have more time for it than you think, because a number of the patients are men. Many others spend their whole time in the consulting room, so that your presence is not needed.

On your desk, and at every telephone extension in the office, keep a pad and pencil—tied down if necessary. If Dr. Barrie is with a patient, record all telephone calls that aren't urgent. Promise you'll call

"I'd say he's well adjusted. He hates everybody."



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of a new

antihypertensive

agent

Apresoline*

Trade Mark

(*brand of hydralazine*)

hydrochloride

* **Clinically investigated as C-5968 and also 1-Hydrazinophthalazine, hydrochloride**

Major Advance in the Medical Management of Hyp

Clinical Significance

By virtue of its dual capacity to reduce blood pressure and yet increase blood flow through the kidney, Apresoline provides a new and improved approach to the medical management of hypertensive disorders. Its value is augmented by its tendency to cause significant relaxation of cerebral vascular tone in hypertensive patients, oral as well as parenteral effectiveness, and relatively low toxicity.

Indications

Apresoline has proved therapeutically useful in widely differing forms of hypertensive disease. The drug is of distinct value in essential and early malignant hypertension, its effectiveness often being more marked in the severe (although not terminal) phases of these disorders. It is also most effective in hypertension persisting or recurring after sympathectomy.

Preliminary studies indicate that worthwhile results also may be expected in toxemias of pregnancy and in acute glomerulonephritis. When renal damage is advanced, as in chronic renal hypertension and chronic glomerulonephritis, the value of the drug is considerably less, and it may be hazardous if not used with extreme caution and constant observation.

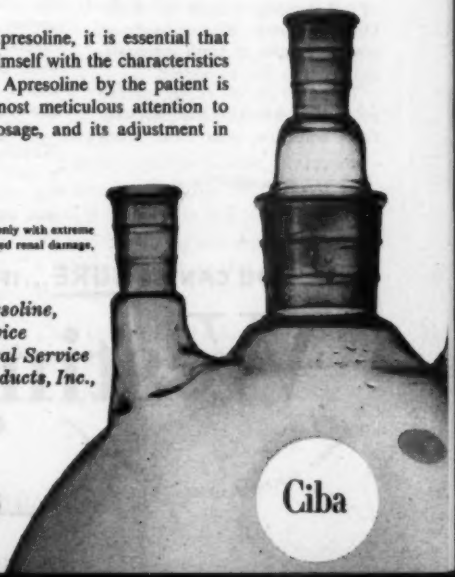
Administration

Before prescribing or administering Apresoline, it is essential that the physician thoroughly familiarize himself with the characteristics of the drug. The benefit derived from Apresoline by the patient is dependent in vital degree upon the most meticulous attention to individualization of administration, dosage, and its adjustment in accordance with response.

Caution

Apresoline, like any hypotensive agent, should be used only with extreme caution in patients with coronary artery disease, advanced renal damage, and existing or incipient cerebral vascular accidents.

For complete information on Apresoline, contact the Ciba Professional Service Representative or write the Medical Service Division, Ciba Pharmaceutical Products, Inc., Summit, New Jersey.



f Hypertensive Disorders

Ciba

back a little later when the doctor is free to talk. This adds greatly to the general smoothness of office hours.

As for making and sterilizing dressings and swabs, I found it best to devote two hours a week on a certain *morning* to this task. By so doing you can easily keep an abundant reserve supply.

It's a Game

This duty was so very dull that it always bored me frightfully until I hit upon the plan of trying to break my own record. I timed myself to see how many I could make perfectly in a minute and whether I could make more by working straight through or by resting one minute out of every ten. I found the latter method much the faster.

With our up-to-date sterilizer, it takes only a little while to sterilize a week's supply. But be sure to get it done by 11 o'clock so the steamy smell will be completely gone before office hours.

Twice a week the laundry is picked up and returned. Twice a week, first thing in the morning, count and list the outgoing, and check the returned, articles. Each of these operations takes only five minutes if you concentrate. Putting the laundry away may take another five. There's thirty minutes out of your week. Why worry about it?

As for checking and ordering supplies, I repeat: system, system, system! Keep a little notebook with a pencil attached to it in the surgical supply cupboard, and another in the stationery and clerical supply closet. Everything should be clearly labeled. When anything is getting low, jot it down in the book. Keep on the first page the name and telephone number of the firms with which you deal. A brief telephone call or a postal card will keep you from running short.

Incidentally, shopping about too extensively for low prices is not good practice. Deal only with reputable and well established firms. Get to know the salespeople personally; establish friendly relations; and "grapple them to your soul with hoops of steel." If you do, they'll give you personal and efficient service. They'll make prompt deliveries on a moment's notice. They'll send up anything on approval. They'll allow you to return for credit anything that doesn't satisfy you. And if they don't have what you want they'll order it for you. Dealing with such people will in the long run save many hours of time and much money.

I hope you feel better, Mary, and not worse after this fusillade of advice. And I hope it'll prove useful! I'll write you again soon.

Meanwhile, take for your motto the old jingle:

That man is blest who does his best
And leaves the rest: Don't worry!

Reassuringly yours,
Myrna Chase

Test Your Collection Psychology

Do your collection letters use any of these stock phrases? Watch out—they can cut down receipts

● Even in collection letters recommended by experts, you'll find many a psychological dud.

What's *that?* I mean a word, a phrase, or a sentence that can rub the debtor the wrong way, thus making him less inclined to pay up.

Some doctors' letters abound with such phrases. If you don't believe it, take a look at the following examples. They stem from collection letters in actual use in medical offices today:

"I feel sure that you must have overlooked my statement."

This is a familiar approach, but bristling with insincerity. Its variations are no more convincing—for example, "You've probably mislaid my last bill," or "Perhaps this overdue account has simply slipped your mind."

Why are these openings psychological duds? Because the patient, as well as the doctor, *knows* they're phony. After having already opened two or three monthly bills, the average person is generally well aware of his obligation. At any rate, it's much more complimentary—and productive—for the physician to assume so.

"In order to meet my own obligations, I must request prompt payment for my services."

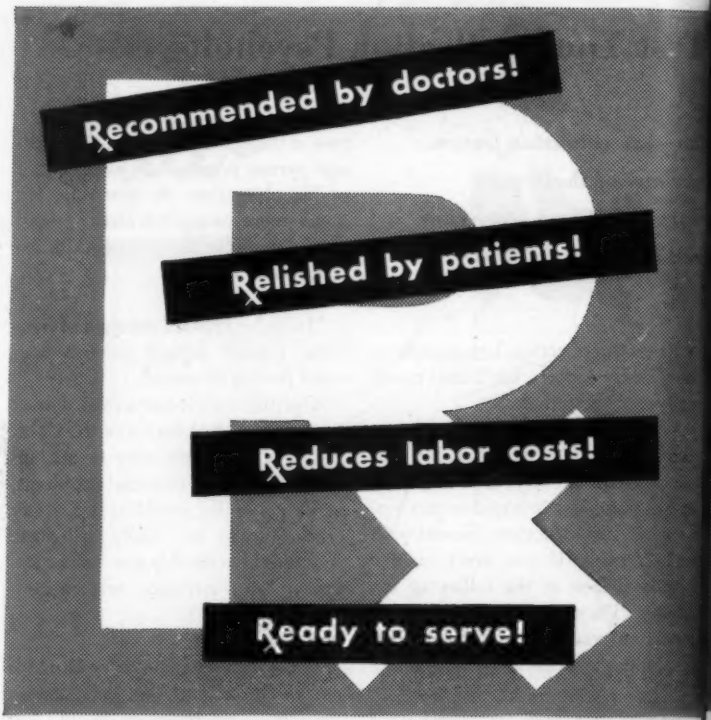
The only valid reason for a debtor to pay up is that he owes the debt. When a physician tries to stir up sympathy for *his* financial problems, he is generally paddling up a dry creek. Worse, he's likely to irritate the patient with this tear-jerker approach. And irritation seldom generates checks.

"I've been checking over Doctor's accounts and find that you haven't yet sent us any payment. Would you mind helping us out?"

What does this secretary think she's doing—soliciting a contribution to the Society for the Support of Dr. Smith? Any such pleading or wheedling puts the physician in a weak, defensive position. It sacrifices his dignity and invites contempt.

"When the courtesy of extended

By James Fuller



Known and recommended by physicians in the 3½-ounce size, Swift's Meats for Babies are now available in a new, convenient 12-ounce size, for hospitals and other institutions.

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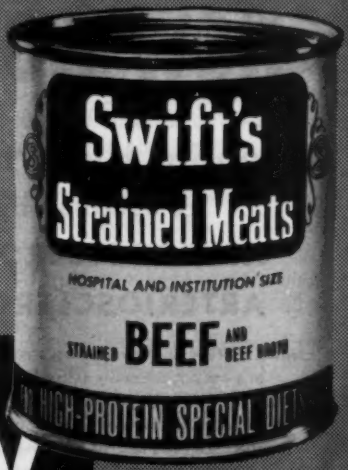
All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.



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payment was originally given you, it was based on my confidence in your honesty."

This rates as a psychological dud because it invites the following reaction: "So I'm dishonest, am I? Well, if *that's* what he thinks . . ." And into the wastebasket goes the letter. Moral: Don't cast aspersions—even indirect ones—on any debtor.

"*I am disappointed that you have failed to make a remittance.*"

If you really want to annoy a person, say most psychologists, just tell him flatly that he's let you down. People don't like to be reminded of their failures in so many words. When they *are* so reminded, they're less likely to cooperate.

"*Unless I hear from you within the next week, I will be forced to take drastic action.*"

What drastic action? The threat is almost meaningless because it's so vague. As a rule, ultimatums are best avoided—at least until the last possible moment. They don't give the debtor enough chance to save face.

"*I didn't fail you when called upon to render service. Why should you fail me?*"

There's that suggestion of failure again. In addition, this gambit plays up the "I" angle (instead of the "you" angle) and sentimentalizes it. Better leave that to Dr. Kildare.

This little exercise in applied psychology is one that even the so-called experts have been slow to learn. One collection authority actually recommends phrases like these:

"I have given you the best within my power . . ."

"The minutes spent in writing you might better be used in saving another human's life . . ."

Patients aren't dumb! They know how much interest the physician displayed in their case; and if it's any less than they expected, this approach may rate as the biggest psychological dud of them all.

After all, a collection letter needs just three things:

1. A brief reminder of the amount owed, along with a direct request for payment.

2. An appeal to the debtor's pride and self-respect, which are the mainsprings of human behavior.

3. A sincere but informal writing style, as if you were simply talking to the person.

If you stick to the friendly, man-to-man approach—"I know you mean to pay"—you'll get results. And, just as important, you'll keep the patient's good will. END

Bachelor From The Bronx

[CONTINUED FROM 92]

would limit the sale and use of fireworks. But Schwartz stayed in the legislative chamber until he was hoarse from speaking. And the bill became law.

Thereafter, Bronx doctors became increasingly active in community affairs. Some of the more spectacular results were described by Schwartz at the A.M.A.'s public relation's conference in Los Angeles last December. Quite typical was the battle over Pugsley Creek.

For years, city authorities had ignored the complaints of residents of the area. Garbage choked the creek; it bred flies, mosquitoes, rats, and a fulsome fragrance that kept near-by windows sealed. Schwartz decided it was a prime health hazard and led an expedition of doctors to the scene. One member of the group actually plunged headlong into the muck while trying to catch a rat.

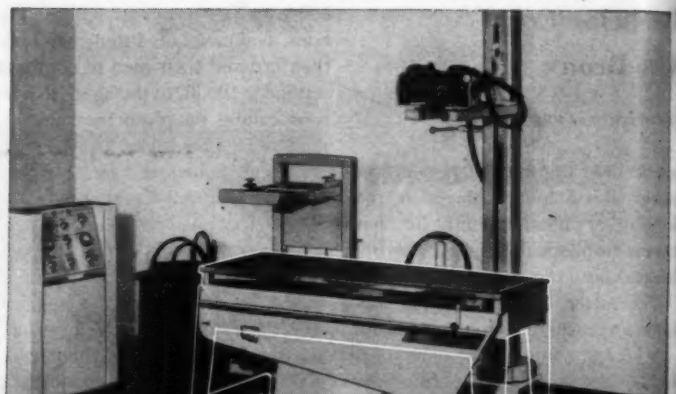
"We let that man have his say in our report to the city," Schwartz recalls. "And as a result, it was a scorcher. We hollered so loud, the city finally hired a private contractor to clean up the mess."

Other civic messes have also brought Schwartz to the scene. Even labor squabbles. Elevator strikers last autumn, for example, found Schwartz intervening within the hour. Union agents listened to him, then ordered their men to continue service to the ill, to the aged, to persons calling on physicians, and to physicians themselves.

George Schwartz's latest enthusiasm is the Bronx Community Clinic, which opened its doors last July. Co-sponsored by the medical society and by the Chamber of Commerce, this Schwartzian venture consists of weekly "town meetings" at which citizens air their complaints about community conditions. Clinic committees then study the symptoms, make diagnoses, and prescribe practical remedies.

Stimulated by plentiful publicity, the clinic is a huge success. Schwartz worked day and night preparing its first major project, "Operation Safety Bronx," which saw 4,000 motorists given free visual, hearing, and driver-reflex tests by doctors in the borough's largest theatre. Programs in accident prevention, citizenship, sanitation, and fair trade are now also being pushed.

Each Wednesday morning when people pour in for this "town meeting," Schwartz arrives early, wondering what he'll end up doing next. The only thing he's sure of is that it will be fun—both for him and for the others involved. "People enjoy being kept busy," he says in his soft Bronx voice, "when they know they're doing good." END



The horizontal Bucky table (inset) can be added to — a step at a time — providing intermediate units until you reach the ultimate in the series, the Maxicon 200.

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When the Tax Auditor Comes

[CONTINUED FROM 71]

less, if the doctor (or his tax adviser) disagrees with the decision, he is free to dispute it. This may give rise to what is known, in tax lingo, as a "bargain."

Here's an example of the "bargaining" process:

Two years ago, an East Coast physician took a lecture trip to Europe. His wife went along as a technical assistant, and he felt that he could legitimately claim two-thirds of her expenses as a tax deduction. The auditor, however, objected; he would, he said, allow only one-third of the wife's expenses.

But the physician made a strong case. He gave examples of how important his wife's services had been. Finally, relenting, the tax man said, "All right. Let's make it one-half."

Sometimes the bargain process is more complex than this. It may involve two or three deductions. Tax advisers have found that they can often sustain one important deduction in full if they gradually soften their arguments for one or two less important ones.

One auditor, for example, disputed the amount claimed by a doctor for membership in a country club where he made professional contacts. He thought also that the rate of depreciation set for a new X-ray machine was too high. The doctor began by defending both deductions, but rather than endanger the more important of the two—the club dues—he soon agreed to a lower depreciation rate. Nothing more was said about the dues.

Orienting the Auditor

Frequently, an auditor will dispute a physician's expenses because he is not familiar with the economics of medical practice. In such cases he may be open to a bit of orientation. One tax man, for instance, began by slashing nearly every professional expense item the M.D. had listed. But he changed his approach when he learned that the doctor had given some $5,000 worth of charity medical care during the year.

Another examiner became more open-minded when he found that the doctor was owed more than $2,000 in unpaid and long-overdue bills.

But tax advisers caution against laboring such points. If it isn't strictly necessary to defend your claims, don't do it. Says a tax lawyer:

"When you hand over your records to a tax agent, you have to think, 'My return is correct and here's evidence of it.' If you begin defending yourself before you're charged, the auditor will surely suspect a guilty conscience."

Though, as I've said, the average auditor is easy to get along with,

doctors are bound to draw a tartar now and then. Maybe you've run into the type: He strikes out a deduction and turns a deaf ear to your reasoning. What can you do about it? One of two things:

Pay up—or if you're convinced you're right:

Protest.

You'll get a chance to protest shortly after the audit has been completed. If the auditor has recommended changes, you'll receive a report on the audit from the agent in charge of your tax district. Along with it, you'll get what is known as a "thirty-day letter." This gives you thirty days in which to file a protest—in which case you'll be granted a hearing with a tax conferee, who may be the head tax man in your district or, in large cities, the district's chief auditor.

If you don't get satisfaction from the conferee, you may be granted a further hearing before the appellate staff, which is like a jury of tax experts. (This right, however, is not guaranteed.)

In most instances, if the conferee and/or the appellate staff turns down your protest, it's best to pay up. Further appeal may prove very costly, since the interest on the amount due continues to pile up as long as you hold off paying.

If you so choose, however, two further avenues of appeal remain. One of these is the U.S. Tax Court, to which you can appeal within ninety days after your hearing with a conferee, if you have *not* paid you assessment. If you *have* paid up b still think you've been wronged, y can sue the Government. This y must do in the U.S. District Court the U.S. Court of Claims.

According to a conservative es mate, you'll be lucky to get court a tion on a tax case inside of thre years. Before then, you may wi want to give up—dismayed, lik Hamlet, by "the law's delay."

In sum, here are the main point to keep in mind when the tax audit calls:

1. Take it for granted that yo return is being audited by chanc don't do anything to make the age think you have a guilty conscienc

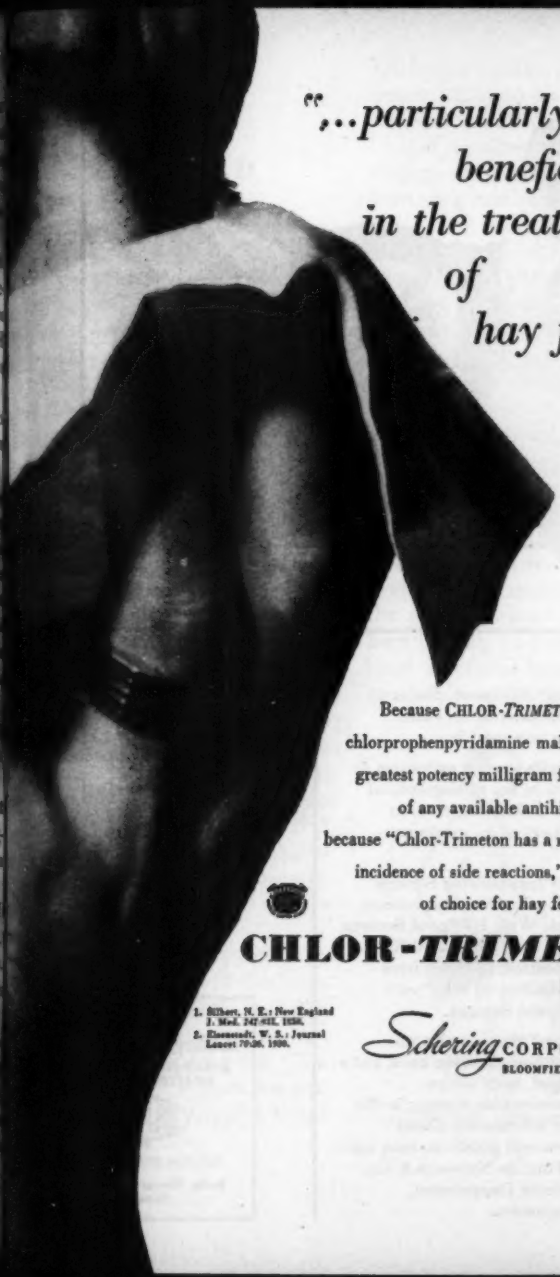
2. Assume that the agent is d ing a difficult job to the best of h ability—that he's no mere Admini tration emissary sent out to mak trouble for doctors.

3. Assemble your records ahe of time; make sure they're comple in every important detail.

4. If you disagree with the agen over certain deductions, rely on log ic and compromise to arrive at a common ground.

5. Where the disallowance o major deductions is in prospect don't hesitate to get outside advice. You don't have to accept the agent's decisions unquestioningly.

6. Don't sign any agreement pre sented by the agent unless you're i full accord with his findings, or u less you've exhausted the variou methods of appeal.



"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

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1. Silbert, N. E.: New England J. Med. 247:811, 1952.
2. Eisenstadt, W. S.: Journal Lancet 70:36, 1950.

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Fee Splitting: How to Combat It

[CONTINUED FROM 88]

affected many M.D.'s. "I don't want the hospital nosing through my books unless it will publicize the fact that I'm not splitting fees," said one.

When St. Joseph's doctors rejected the proposals, the staff was dissolved in a surprise action by the Third Order of St. Francis, which owns and operates the hospital. Then it was reorganized—under the new by-laws. Of the forty-eight doctors on the attending staff at St. Joseph's at the time it was dissolved, forty-six have come back on the reorganized staff. The other two have died.

In this case, the control of surgical privileges was also at issue. It may, therefore, have been as important as the proposed action against fee splitters in bringing about the crisis that resulted in dissolution of the staff. From the hospital's standpoint, however, the two regulations were both part of a single effort to raise hospital standards.

"Protection of the patient is the greatest responsibility of the hospital and the medical staff," said Rev. John Weishar of Peoria, diocesan director of Catholic hospitals. "The Third Order of St. Francis, the governing board of St. Joseph's Hospital, feels it owes an obligation to the community to operate a fully accredited hospital."

Staff members of the American College of Surgeons report that an increasing number of hospital boards are feeling some responsibility for medical standards. But it would probably take years to eliminate fee splitting by hospital actions similar to that of St. Joseph's.

Meanwhile, unquestionably, fee splitting could be swiftly curtailed if the Commissioner of Internal Revenue issued a formal regulation for its collectors in the states where fee splitting is held illegal. That regulation would instruct tax men to rule against the deduction of referral fees as business expense. This action would not, of course, eliminate all the phony surgical assistance and joint billing and other sleight-of-hand tricks that have been used to conceal fee splitting. But it would

"He was playing doctor."

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PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

cut out the hard, dark core of the problem, the secret split that defrauds the patient and casts a shadow on the profession.

As this is written, the Board of Regents of the American College of Surgeons is favorably considering one proposal to speed up the pace of its long fight against fee splitting. It has been suggested that the board adopt resolutions *publicly* requesting the Commissioner of Internal Revenue to take a firm position on the deduction question.

Moreover, medicine's top ruling body, the House of Delegates of the American Medical Association, has thrown its weight behind a drive to make rebates unlawful in all states. The A.M.A. Principles of Medical Ethics are of course adamant against "the giving or receiving of a commission . . . under any guise or pretext whatsoever."

Some observers find it ironic that a result long sought through ethical codes and professional standardizing bodies can apparently be attained only by bureaucratic regulation. Actually, this isn't the point at all.

Fee splitting develops as a response to economic pressures on the doctors who practice it. The most logical way to prevent it is to develop equally strong, counterbalancing pressures *against* fee splitting. If the Bureau of Internal Revenue produces such pressures, it will simply reflect what the medical profession itself apparently desires. END

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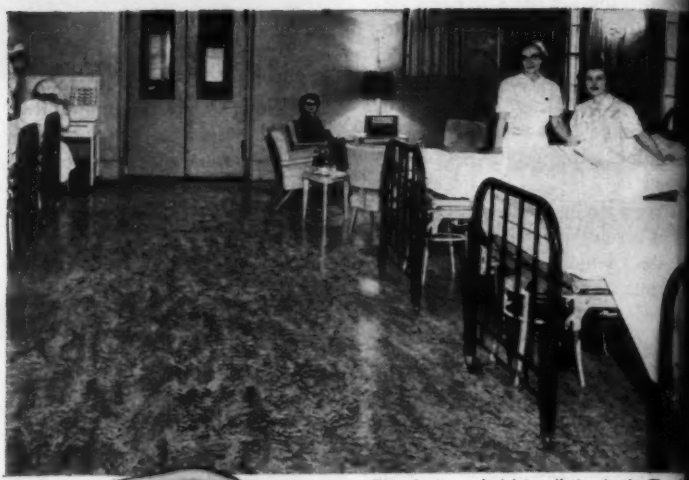
"But I'm not due for an ulcer . . . I'm only a junior vice president!"

This hospital floor will look like new for yea



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got the floor, and you've got it *for go*
with *long life...enduring beauty...e*
maintenance...true resilience...and
good-as-gold Gold Seal guarantee
complete satisfaction or your money ba

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Disperse instantly in fruit juice or water; mix readily with formula

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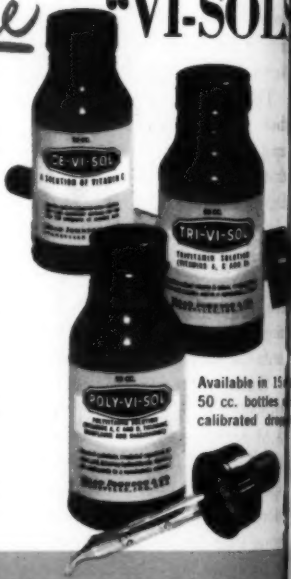

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Urges Doctors to Press For Fee-Splitting Laws

The fact that fee splitting is "apparently legal" in twenty-five states makes it important for physicians in those states to seek legislation aimed at stamping out the abuse. So argues the Norfolk (Mass.) Medical News.

The editors chide physicians in their own state for failing to follow up a four-year-old A.M.A. resolution that urged state societies to support legislation against "the acceptance . . . of rebates in any form." In 1950, they say, "we were told by the Committee on State Legislation that the reason for not drafting such legislation was that 'it . . . might lead to unfavorable and unjust publicity . . .'"

Dissatisfied with this reasoning, the journal recently asked the A.M.A. Bureau of Legal Medicine and Legislation what difficulties sponsors of anti-fee-splitting legislation have run into. The answer: none that the bureau knew of.

Commented Director J. W. Holloway Jr.:

"The only persons who could oppose it would be physicians who do engage in fee splitting . . . and corporations who engage in the practice of making rebates, and it is inconceivable to me that the . . . legislature would look with much favor on the testimony presented by either group."

Is Your Old Diathermy Equipment Obsolete?

At the end of this month many diathermy units now used by physicians will be obsolete—even though lots of them may be in good working order.

As the result of a Federal Communications Commission edict, most diathermy machines manufactured before July 1, 1947, cannot be used after June 30 of this year. If you own a diathermy that was *built* after July 1, 1947, chances are that it's been set to operate within the four frequencies newly assigned for medical use by the F.C.C. You can tell whether you've got an up-to-date machine by checking its name tag. It's O.K. if you find an F.C.C. "type approval" number on the tag. This means that a prototype of the instrument has been tested and approved by the F.C.C.

What's the reason for the June 30 change-over? The buzz emitted by diathermy equipment—used by many industrial firms as well as by physicians—was coming through


Efficient spasmolysis,

...in functional disorders

. . . such as irritable colon, emotional diarrhea, peptic ulcer, pyrosis; also for inflammatory diarrhea due to acute gastroenteritis or ulcerative colitis, and functional dysmenorrhea.

Elixir

BUTISOL® - BELLADONNA

—has a more definite, efficient antispasmodic action because it combines in each 5 cc. (one teaspoonful):

1 • BUTISOL® SODIUM 10 mg. (⅙ gr.)—"intermediate sedative" which is "particularly useful in the field of daytime sedation."[1] The mild, relatively prolonged action of Butisol Sodium "makes it suitable for management of many functional disorders."[1]

2 • EXT. BELLADONNA 15 mg. (¼ gr.)—in its preferred and most effective form—the *natural* extract rather than the synthetic alkaloids.

...in an exceptionally pleasant-tasting elixir colored an appetizing orange-red. Supplied in bottles of one pint and one gallon. Samples on request.

1. Dripps, R.D.: Selective Utilization of Barbiturates, J.A.M.A. 139:148 (Jan. 15) 1949.

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LESS FRICTION between barrel and plunger, reducing syringe-wear.

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SEE THE NEW B-D *Dynafit*® SYRINGE at your dealer's in 2 cc., 5 cc., and 10 cc. with Luer-Lok or Luer Metal Tips.

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adio receivers like a howling ban-
hee.

Police short-wave radios and air-
o-ground and ship-to-shore systems
ave been reacting to the interfer-
nce for years. And, more recently,
elevision screens have been flutter-
ng. With the airwaves in something
f a jumble, the communications
eople have found it necessary to
rrow the channels on which vari-
s types of transmitters can oper-
e.

Under certain circumstances, it's
ossible to continue using an old-
yle diathermy. If, for example, you
rovide a shielded room and use a
ltered power line to cut down the
diation, the F.C.C. may not object.

To operate a pre-1947 machine
nder these conditions—or any other
nditions—you must display a cer-
icate from a radio engineer to the
ect that the radiation from your
uipment does not exceed that per-
tted by the F.C.C. Ordinarily,
oviding such protection will be
o expensive a proposition for the
erage physician. Surgical diather-
y equipment in hospitals is, in
st cases, already screened and
ll not be affected by the new reg-
tion.

A big question right now is: Can
e old diathermy machine be con-
erted to comply with the new reg-
lations? A great many electronics
en say the average old-style equip-
ent cannot be converted. There
re some, however, who believe the
ob can be done on some types of
machines. In any case, it's doubtful that any conversion job will be guaranteed.

If you're one of those who must trade in a still-usable diathermy for a new model, you may draw some comfort from the fact that you can get tax credit for any loss you sustain. The tax man will let you add such loss to the purchase price of your new diathermy equipment, for depreciation purposes.

Guilty Pharmacist Views Drug Addicts' Brawl

The occasional physician who is careless with drug supplies and prescription blanks may be playing into the hands of men like Enos A. Hilterbrand. It's unlikely, though, that Druggist Hilterbrand himself will ever again accept the gambit.

Convicted for the illegal sale of barbiturates, Hilterbrand was glumly awaiting sentence in a Federal court in Dallas, Tex., when seven young drug addicts were brought before the bench. They were still hopped up. Two of them attacked court attendants. A third—a teenage girl who was pregnant—severely bit attendants when they tried to take a barbiturate capsule away from her. Unable to control the young defendants, Judge T. Whitfield Davidson ordered them held for trial at a later date.

Then he meted out to Enos Hilterbrand the stiffest penalty ever imposed by a Federal court for the

illegal sale of prescription drugs: two years in the penitentiary. Judge Davidson served notice to all people who deal with drugs that no probated sentences will be given in his court.

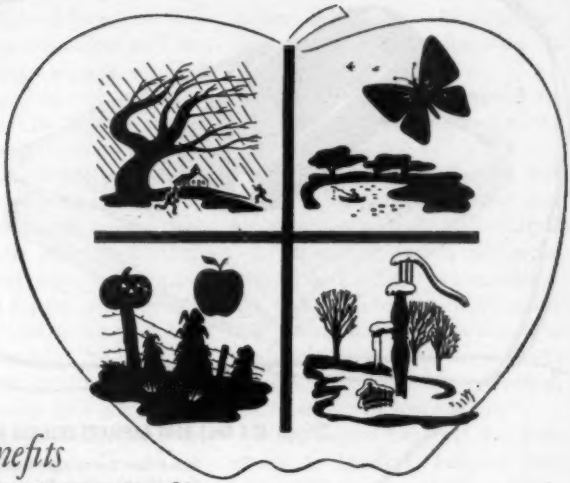
Tour of A.M.A. Exhibits Is Featured on TV

Mobile television units are moving into Chicago's Navy Pier this month, to give the American public an unprecedented glimpse of the 101st annual session of the American Medical Association. Half-hour highlights from the A.M.A.'s scientific exhibit are being carried to a nationwide audience over the National Broadcasting Company's television network on the evenings of Tuesday, June 10, and Wednesday, June 11.

During the two telecasts, home viewers in more than thirty-six cities across the nation are being taken on a tour of the convention's 300 scientific exhibits. The programs are being conducted on a "strictly scientific and educational level," reports the Smith, Kline & French Laboratories of Philadelphia, which is sponsoring the history-making telecasts in cooperation with the A.M.A. Bureau of Health Education.

Local Doctors Sponsor Catastrophic Coverage

From Wisconsin comes the latest sign of Blue Shield progress in extending coverage to catastrophic il-



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Appella Apple Powder — for efficient treatment of diarrhea — is neither a seasonal medication nor exclusively a children's remedy. It can be administered to all members of the family, at any time of the year. It provides the valuable properties of good, ripe apples throughout the year.

The logic and value of a high caloric diet, including Appella, in infant diarrhea, are emphasized by O'Keefe[1]:

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SUPPLIED: 7 oz. jars for prescription use; 18 oz. jars for hospital use.

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1. O'Keefe, Edward S.: Rhode Island Med. Jour., 33:127, Mar., 1950.
2. Council on Foods, American Medical Association: Accepted Foods and Their Nutritional Significance, Chicago, American Medical Association, 1950, p. 288.

7½ gr.

7½ gr. (0.5 Gm.) *BLUE* CAPSULES CHLORAL HYDRATE—*Fellows*

• DESIRABLE SLEEP

lasting from five to eight hours, usually free from undesirable after-effects. Pulse and respiration are slowed in the same manner as in normal sleep. Reflexes are not abolished and the patient can be readily aroused.[3] "CHLORAL HYDRATE produces a normal type of sleep, and is rarely followed by 'hangover'."[4]

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• DAYTIME SEDATION for the patient who needs daytime sedation and relaxation with complete comfort.

Dosage: One 3¾ gr. capsule three times a day, after meals.

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EXCRETION—Rapid and complete, therefore no depressant after-effects.[3, 4]

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BIBLIOGRAPHY
1. Nelson, N. Y.: An Integrated Practice of Medicine (1950)
2. Feldman, G. B., ed: A Digest in Practical Therapeutics (1949)
3. Goodman, L., and Gilman, A.: The Pharmacological Basis of Therapeutics (1941), 22nd printing, 1950.
4. Sollmann, T.: A Manual of Pharmacology, 7th ed. (1948), and Useful Drugs, 16th ed. (1947)

nesses. The Medical Society of Milwaukee County now offers such insurance to groups already enrolled under its basic medical-surgical plan. It is one of the first county societies in the country to do so.

The new Milwaukee contract is modeled on large-scale catastrophic coverage plans elsewhere. For any one illness, after the first $200 in medical-surgical expenses, it pays 75 per cent of further costs up to a maximum of $2,000 in one year. The plan does not restrict the major illnesses for which it will pay.

As yet, coverage does not include hospital benefits. It does include most other items, however—for example: charges for medical and surgical services, registered nurses, X-ray and laboratory services, physiotherapy, medicine and drugs, artificial limbs, and oxygen.

Iowa Medical Society O.K.'s Joint Billing

The A.M.A. has long frowned on the practice of two solo physicians' sending a joint bill to a patient, whether the bill is itemized or not. Iowa doctors, however, have recently taken official exception to this stand.

In a new "interpretation" of medical ethics, the executive council of the state society says this:

"Where two or more doctors render service to a patient, one statement may be submitted by either doctor." Furthermore: "This fee may be entirely paid to either physician, and the one receiving payment shall forward to the other his fee."

This procedure is approved for Iowa doctors on the following conditions:

1. "One statement may be submitted to the patient by either doctor, itemizing each doctor's charge."

2. "It should be made clear to the patient or his legal representative that this fee is to be divided equitably among all physicians who have rendered services, and the patient's consent, either express or implied, obtained as to such procedure."

What factors have led the Iowa society to decide in favor of joint billing? The council cites these among others:

¶ With increasing specialization, it has become frequently necessary for two or more physicians to participate in the treatment of the patient.

¶ During surgery, two or more doctors must be present to insure the patient's welfare in case of emergency. This is a requirement, in fact, in many hospitals.

¶ In large and small Iowa communities, it is common practice for the G.P. or family physician to be present at surgery, often at the specific request of the patient's family.

¶ In many communities where doctors have handled surgical and other cases together, they have rendered one bill with the patient's consent, and frequently at his request. Thus, by custom, joint billing is, in

these localities, an established practice.

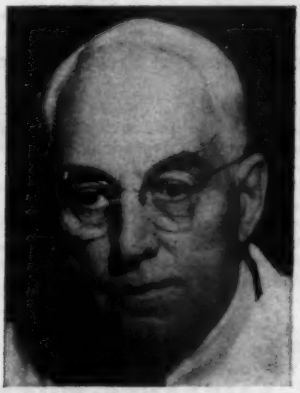
In short, doctors do it, the public accepts it, and the Iowa State Medical Society now recognizes it as ethical. According to law, the Iowa doctors are on safe ground. In their state, joint bills are apparently legal if itemized, illegal if not.

Court O.K.'s Health Plan That Doctors Oppose

A West Coast medical society has suffered a double-barreled legal setback at the hands of the Complete Service Bureau, a lay-controlled voluntary health plan.

In California Superior Court recently, Judge Arthur L. Mundo ruled that the bureau could stay in business despite a charge by the San Diego County Medical Society that it was engaged in the "corporate and lay practice of medicine." The judge also held that George Roy Stevenson, Chester J. Antos, and Robert L. Williams—three physicians who claim to have been barred from medical-society membership because of their connection with Complete Service Bureau—could press a suit for $100,000 damages against the society. (Though Williams resigned from C.S.B. some time ago, he has decided to remain a plaintiff in the suit because, as he puts it, "of the moral issue involved.")

To back up its charge against the bureau, the society pointed out that the bureau's lay manager, David Parmer, was compensated through



Chester J. Antos **George Roy Stevenson**

Their "moral issue" sports a $100,000 price tag

a commission deal amounting to twenty-five cents per member per month. In effect, claimed the society, the plan's physicians were splitting fees with laymen—thus putting laymen in the position of competing with M.D.'s in the practice of medicine.

Not so, ruled Judge Mundo. Regarding Parmer's contract, he commented:

"One would be justified in concluding that [Parmer] had imposed exacting terms for his management of C.S.B. But whether or not the terms were excessive or unconscionable, as the [society contends], this court is not called upon to decide . . . No member of C.S.B. has objected to the contract or to the management of C.S.B., nor has the Attorney General objected to the manner in which C.S.B. is functioning as a nonprofit corporation. The evidence indicates with certainty that C.S.B. under Parmer's management has prospered, has grown to about ten thousand members, its

Anecdotes

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medical staff increased from three to ten physicians, its medical and patient-members satisfied . . . The offer of the defendants to show that C.S.B., while professing to be a nonprofit corporation, is, in fact, a one man profit corporation run by Parmer, must be held to be immaterial."

Nor did the judge find any evidence that "lay intervention exists between patient and doctor." Rather, he said, "the lay staff of C.S.B. handles only the business affairs of the corporation; . . . the organization as a whole operates to the benefit of the patients and the doctors as well."

Judge Mundo drew a parallel between C.S.B. and the doctor-sponsored California Physicians' Service. "Both . . . are entitled to operate under the laws of the State of California," he pointed out. "Neither [has] engaged in the practice of medicine. Actually what these organizations are doing is to bring patient and doctor together under an arrangement which offers their member-patients medical care at reduced cost . . .

"The practice of medicine begins when a person does something in the way of diagnosing or treating the sick. The bringing together of patient and doctor is not a violation of the law."

In short, he went on, "the fact that C.P.S. is subject to control by doctor-members, and that C.S.B. is subject to control by patient-members, does not operate to make the one a lawfully conducted organiza-

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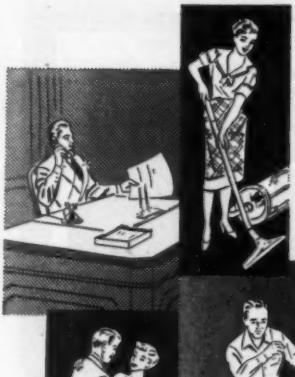

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tion and the other unlawful . . . The law offers no special concession to the medical profession in the management of nonprofit organizations which supply medical care to their members."

Did the bureau constitute unfair competition to physicians? That possibility, too, was ruled out by the judge. The plan *did* offer competition, he conceded; but "the same can be said of the clinics conducted by doctors in partnership arrangements."

In fact, he added, "there are many who . . . hold that group practice will be beneficial to the profession . . . The increased interest in health and medical service would have the natural reaction of bringing many to the individual practitioner who otherwise might be prone to defer their visits to a doctor's office . . . In any event, in this particular case there is no evidence that any practitioner in San Diego has suffered, or will suffer, loss of practice and financial damage because of the operation of C.S.B."

Says M.D. Carelessness Puts Men in Khaki

Doctors are to blame for the drafting of many young men who are not physically qualified for military service, says the journal of the New Jersey medical society. And it rebukes those of its members who fail to cooperate with military medical officers at induction stations.

Of 100 letters of inquiry sent to family physicians by the Newark induction center recently, says the journal, eighty-three were answered within four weeks; seven were acknowledged a month later, after a follow-up letter; ten were "blandly" ignored.

Of the ninety replies that were received, about half were of the "I treated John Smith for asthma five years ago" variety. "Of what value is this in determining the selectee's military fitness?" asks the journal.

It adds: "If the doctor fails to support his own patient's story, either by sending a hopelessly inadequate reply, or by refusing to submit any answer, then he is certainly failing his patient."

Do We Need White Jackets —or Strait Jackets?

If you ever watch TV commercials, chances are you've seen the white-jacketed, well-combed young man who is the electronic age's latest contribution to health and sanity.

He probably doesn't fool you much; but in the public's eyes the TV announcer's new uniform—the white jacket—"identifies [him] as a doctor," writes Charles W. Morton in the Atlantic Monthly. Of course, the announcer doesn't *say* he's a doctor (he'd hear from the Federal Communications Commission if he did); but, Morton explains, "with the white jacket he doesn't have to. Even the dumbest member of the

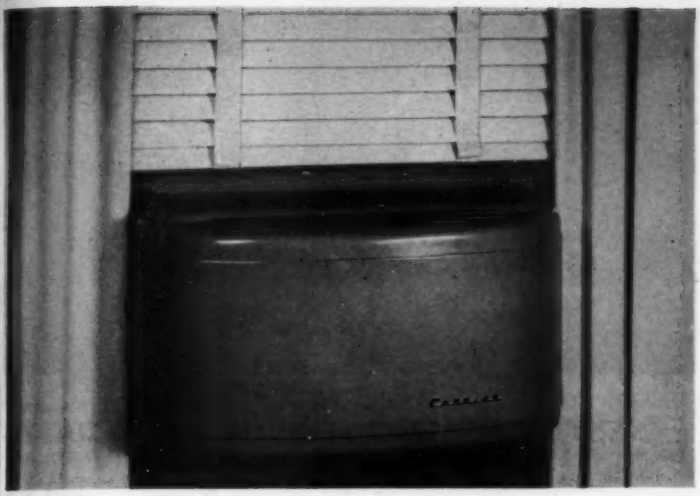
TV audience can see for himself that a doctor is doing the talking."

Usually, the "doctor-announcer" begins his spiel with these words: "In my profession, we turn to the specialist for expert advice. And noted specialists agree . . ." What White Jacket fails to mention, Mr. Morton points out, is that "his profession is in fact commercial announcing."

From this reassuring beginning, the doctor-announcer goes on to the more scientific aspects of the product he's rooting for. And what might that product be? In Morton's words: "The answer is everything: the twice-daily cathartic, the sovereign pill for nephritis, the remedial cigarette, wrist-watch bands, wave lotion, slip covers, carpeting, beer, or small loans."

You may wonder what some of these things he's peddling have to do with a consumer's health. There'll be no doubt in your mind, says Morton, when you hear the pitchman say, "Don't waste money on a wrist-watch band that will constrict your circulation and probably make your fingers drop off" or "Do you want to get pneumonia by using the wrong kind of fuel in your furnace?"

"The health angle and the white jacket," Morton writes, "are said to be alarmingly successful in tipping over the TV audience. If the advertised product happens to tie in comfortably with a specific disease—arthritis, rickets, myocarditis, or lockjaw—so much the better, but if no really formidable ailment can be reasonably hitched up with the sales



What to look for in a room air conditioner

There are 18 important points to look for in a room air conditioner before you buy . . . points that will be even more meaningful to you *after* you buy. And they're all described fully in the new Carrier Buyer's Guide.

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talk, the announcer-doctor can always pick on worry. The TV audience, in other words, can be made to worry about almost anything, and nobody appreciates the dreadful consequences of worry more knowledgeably than the man in the white jacket on the TV screen."

Atoms Make Gold for M.D. Says Frontier Newspaper

Would you like to earn $2.30 a minute ($138 an hour) giving physical examinations? According to a recent editorial in the Las Vegas (Nev.) Sun, one M.D. actually got this rate of pay while working at an Atomic Energy Commission construction project. The Gold Rush was never like this, the editorial implied.

But the Sun, it turned out, had been a little hasty. It was a good story but not altogether accurate, in the light of a subsequent release by the A.E.C. The commission agreed that the physician had billed it $6,000 for examining 150 workers at the Nevada atomic proving ground, just as the newspaper charged. The fee for each examination, it also agreed, had been $40, of which $17 apparently went for laboratory work. But the Sun's claim that the doctor's share of the total charge ($3,450) was earned by "twenty-five hours of toil" did not seem to stand up.

The job of clearing men for urgent work in a radioactive area required, said the A.E.C., not twenty-five but fifty-four hours of the physician's time. He worked, according to the A.E.C. statement, at a rate of eighteen hours a day for three consecutive days. Moreover, he used the services of three technicians, a nurse, and a secretary, most of whom worked overtime on each of the three days.

As for the bill, the $40-a-man charge broke down this way, according to the A.E.C.: X-ray photographs, $10; blood count, $5; urinalysis, $2; X-ray interpretation, $5; physical examination, $18. The commission did not say which of these fees were pocketed by the doctor and which went to the medical group whose laboratory facilities he used.

At last report, Government auditors were still checking over the bill.

Are You 'Short-Changed' On Old-Age Benefits?

Doctor, lawyer, Indian chief—or pharmacist? Which one gets the best break when he retires? Without discussing the obvious advantages of being a retired Indian chief, it's the pharmacist by a long shot.

So says Dr. Harold Aaron, writing in the left-leaning Physicians Forum Bulletin. Doctors and a lot of other professional men are, he maintains, "short-changed" for sums ranging from $7,000 to $20,000 when they retire. Reason: They don't get Federal Social Security benefits, which are available to pharmacists and

many other self-employed people.

Here, according to Aaron, is the situation in a nutshell:

¶ A physician and his wife, both age 60, would have to make a lump-sum payment of at least $20,000 to a private insurance company in order to augment their annuity program by $120 a month when he retires at 65.

¶ A self-employed pharmacist and his wife, who are also both 60, would get exactly the "same annuity program" through Federal Social Security. And they'd get it for a total cost of $513, payable over a five-year period.

It's not only the *older* physician who's being "deprived," says Dr. Aaron. "Actually," he writes, "every doctor who wants to duplicate the retirement benefits now available under Social Security . . . will pay from 200% to 4,000% more to a private insurance company . . ." For example, a 30-year-old professional man would have to pay $5,292 for Social Security as against $12,900 for similar private insurance over a period of thirty-five years.

And when he begins to collect his insurance, the Social Security cardholder will save even more money, Aaron contends. Why? Because Social Security benefits are tax free. What's more, he adds, there are no jokers in Government insurance: "Under Social Security no one can be charged more or excluded because of ill health or occupational hazard."

Why aren't physicians entitled to Social Security? "This discrimina-

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tion . . . is primarily the result of a successful lobby on the part of the American Medical Association," says Dr. Aaron. The A.M.A., he points out, has condemned Social Security as a "compulsory socialistic tax."

Already a national dentists' group is backing legislation that will make the D.D.S. eligible for social security. And, Aaron reveals, the Physicians Forum is planning to introduce similar legislation for medical men this fall. "Doctors," he concludes, "should join the Physicians Forum in urging their constituent medical societies and . . . the A.M.A. to reconsider their denunciation of Social Security."

Are Grievance Committees Often Too 'Bashful'?

Although more and more state societies are setting up grievance committees, a good many still hide their light under a bushel. This is apparent from a recent progress report published by the A.M.A. Council on Medical Service.

Only eight states, as compared with fourteen in 1950, now lack machinery for handling grievances "on a state-wide basis," says the council. Of these eight, one (South Carolina) is planning to vote on the matter this year, and three (New York, North Dakota, and Oregon) are studying it. The remaining four (Alabama, Pennsylvania, Mississippi, and Maine) are not now considering the formation of grievance committees.

Of the states with grievance committees, only about half have publicized them; and in many cases publicity has been limited to an initial announcement. The reason given by several states for staying mum: Publicity might encourage ill-founded and nuisance complaints or might be looked on as a defensive action.

The council scotches both arguments. Complaints from cranks and psychopaths are common the first few months, it says, but they taper off later. As for the impression of some laymen that a grievance committee is evidence of an apologetic or defensive attitude: This disappears "as soon as it becomes apparent that the committee is interested in only a just settlement . . . and will defend whichever party is in the right."

Why set up *county* grievance committees* when so many *states* have them? Because "disciplinary action must either originate or end" at the local level.

As the council points out, a local committee can usually settle cases more quickly and effectively because it's closer to the problem. What's more, the handling of grievances at the county level is better public relations, since the public is likely to regard such action as a "self-disciplinary measure" rather than a po-

*At last report (early 1951), 568 local societies had such committees.

licing action by an "outside" group.

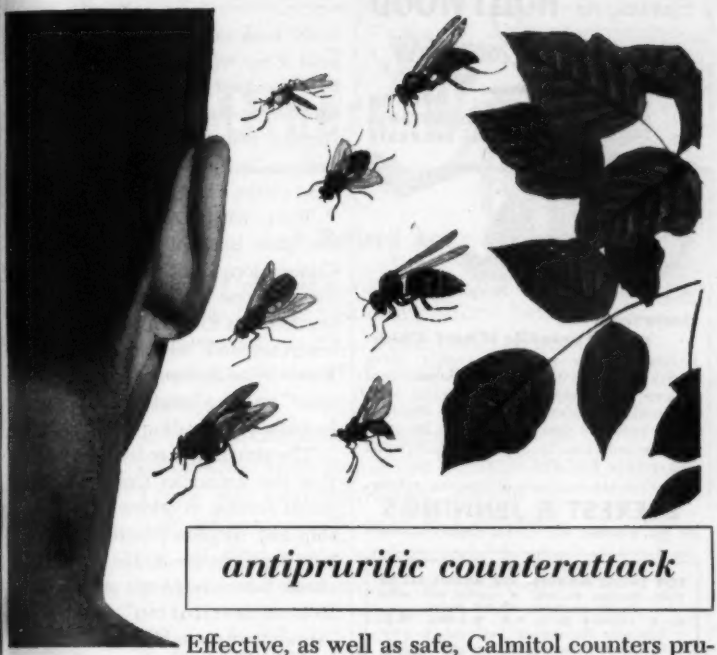
Where, then, does the state grievance committee fit into the picture? When there's need for a "court of appeals" or when an impartial or thorough hearing at the county level is impossible, says the council.

Some physicians tend to forget that a grievance committee serves *their* self-interest as well as the public's. Observes the council: "Where a physician has been unjustly criticized or condemned, it is to the benefit of the physician and the entire profession that the individual physician's record be cleared. The grievance committee is a protective mechanism for both the public and the medical profession and should be looked upon as such."

Even though few complaints are brought before a committee, it's still a valuable mechanism, the report concludes. For one thing, it "demonstrates the profession's willingness to discuss problems of medical care with the public. Its very existence is a deterrent to those . . . [doctors] whose individual actions might do harm to the profession's reputation."

Alerts Patients Against 'Ghost Surgery' Menace

"The ghost surgeon, clothed in white, moved silently into the operating-room. The sterile gauze that covered his mouth and nostrils might appropriately have been a highwayman's mask . . . Wielding a scalpel instead of a weapon, the surgeon cut open his [anesthetized] victim's



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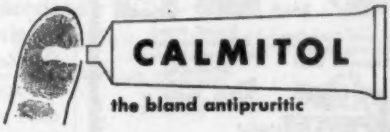

1. Lubowe, I.I.: New York State Journal of Medicine 50:1743 (July), 1950.

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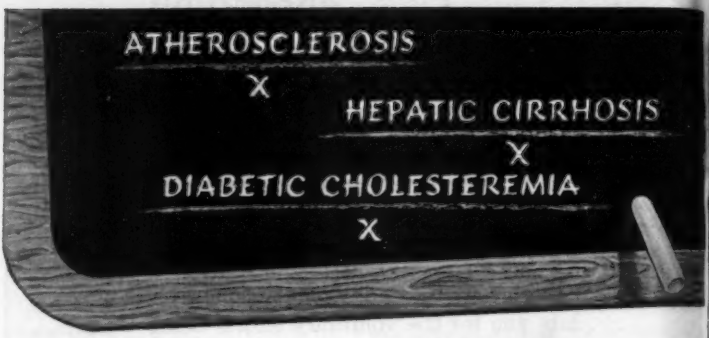
body, took out a healthy appendix, held it up with a sharp look at his fellow culprit, who stood by, sewed up the gaping wound, gathered his surgical instruments and left as silently as he had come, while the patient-victim slept on."

Thus, writes Albert Deutsch in the May issue of Woman's Home Companion, "another piece of ghost surgery—one of the most vicious practices in modern medicine—had been executed." His article, "Do You Know Who Performed Your Operation?" paints a lurid picture of what he calls a "spreading evil."

The situation is so bad, he asserts, that the American College of Surgeons refuses to admit to membership any surgeon practicing in certain populous areas. He cites an instance where residents at "a famous Boston institution" were paid "twenty-five to fifty dollars plus traveling expenses for their ghostly excursions into small-town operating-rooms." This wasn't stopped until "the A.C.S. let it be known that the guilty residents were being closely watched and that evidence of performing ghost surgery would bar them in their later careers from admission to the college."

To shed some additional light on what makes a doctor drift into ghost surgery, Deutsch describes the experience of a "Dr. Zero"—a flourishing ghost surgeon in an Eastern city. Dr. Zero once had the makings of an excellent surgeon; but in the early days of his career, says Deutsch, "there were long waiting periods between patients, and he barely



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Riboflavin	0.5 mg.
Nicotinic Acid	5.0 mg.

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made a living for himself and his family. His shy retiring nature didn't attract patients—they preferred confidence and cheeriness in their doctors." So when a general practitioner offered him $40 to perform a ghost operation, he grabbed the chance. Why? "Because he needed the money and because he felt such a job would keep his skill from getting rusty."

Word soon got around that he was a willing and able ghost surgeon, recounts Deutsch, and "many unethical practitioners took to using his operating skill to line their own pockets. In due time Dr. Zero was flitting busily in and out of operating-rooms, cutting up people who never saw him or knew his name. He raised his fees as a ghost, moved his family into a better neighborhood and pleasured himself with an expensive hobby. He adopted a highly cynical view of mankind and medicine that contrasted sharply with the idealism of his medical school days."

Whose fault is it that surgeons like Dr. Zero go astray? As Deutsch sees it, much of the blame lies with the "older men" who tempt young surgeons "during the difficult days of trying to build up a practice." But he also scores the A.M.A. for allegedly failing to take "vigorous action against the shady characters who disgrace their profession."

How can readers of Woman's Home Companion protect themselves against the doctors' peccadilloes? Deutsch suggests two ways:

1. Before signing a certificate authorizing an operation, patients should insist on having the operating doctor's name entered in the proper space.

2. They should insist, too, on receiving a copy of the hospital's record of the medical participants in an operation.

"No ethical doctor," he adds, "should feel resentful when a patient exercises his rights. Bashfulness should not be a bar when health and perhaps life are at stake."

16 Million Patients—And Only 100 Doctors

People who think there's a doctor shortage in the U.S. should visit Afghanistan. There the doctor-patient ratio is about one to 160,000; 100 physicians serve a population of 16 million!

This was one of the facts reported in a recent World Health Organization study of health needs in Southeast Asia, a 500-million-person area comprising Afghanistan, Burma, Ceylon, India, Indonesia, and Thailand. In these countries, smallpox, plague, cholera, typhoid, malaria, and other communicable diseases have kept the life expectancy down to between 25 and 35 years.

With the U.S. and the U.N. together sending between $16 and $19 million in annual aid to this deprived area, there is some hope that local governments can be stimulated to

lift health standards. But, as Dr. C. Mani, director of W.H.O. activities in Southeast Asia points out, 80 per cent of the people in the area are illiterate, and the average annual income is only about $50 a year. "All public health planning must start with these facts," says Dr. Mani.

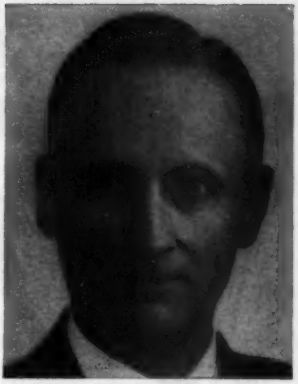
Seeks Federal Aid for Ambulance Services

The doctor is sometimes criticized for not getting to the patient quickly enough in an emergency. Less often is criticism directed at the speed with which the patient gets to the doctor.

The big need, as Representative Louis B. Heller (D., N.Y.) sees it, is more efficient ambulance service. He thinks every city of 100,000 or more people should have a radio-controlled ambulance system. To help a city set up and operate such a system, Heller has introduced a bill calling for the Government to share in up to 10 per cent of its cost.

High Fees Not the Only Trouble, Says Committee

It's no secret that excessive or unexpected charges for medical services bulk large among the complaints that patients voice against their doctors. But "incompetent," "negligent," and "discourteous" treatment are also important sources of grievances, says the District of Columbia medical society.



Walter R. Stokes
How to stir up grievances

In a report on cases handled by its grievance committee during a twelve-month period, the society lists these examples (among others) of alleged poor treatment that led to formal complaints:

¶ Experimentation with untried methods of treatment;

¶ Failure to use modern methods;

¶ The guaranteeing of therapeutic results that failed to materialize;

¶ Unfounded and frightening diagnoses or prognoses.

One fairly frequent type of complaint did not involve the doctor directly. It was: "Discourteous treatment at the hands of members of the doctor's office staff or family."

Some patients who bring charges against doctors are "clearly irrational," according to Walter R. Stokes, chairman of the committee. But he

Protected for a whole day

'Perazil' gives practical protection from the effects of allergens. Observers have agreed that: "The percentage and severity of side reactions was very low. Due to the longer duration of action of 'Perazil', less frequent administration of tablets was necessary."[1]

'Perazil' was developed by The Wellcome Research Laboratories in the search for an ideal antihistaminic. Its chemical composition is unique. One 50 mg. tablet acts for 12 to 24 hours as a rule in relieving allergies.

'Perazil' **Cream** may be used for topical antihistaminic and antipruritic effect.

'Perazil'® brand

Chlorcyclizine Hydrochloride, 50 mg., Compressed, scored . . . also 'PERAZIL'® *brand Chlorcyclizine Hydrochloride* CREAM *1%*

1. Cullick, L., and Ogden, H. D.: J. So. Med. Assn., 43:643, 1950

Burroughs Wellcome & Co. (U.S.A.) Inc., *Tuckahoe 7, N. Y.*

points out that the doctor can often avoid trouble with such persons by "displaying forbearance and tact, instead of standing stiffly upon his sense of justice."

On the other hand, when the complaint is justified or the doctor fails to cooperate, the D.C. committee doesn't hesitate to take disciplinary action. Explains Dr. Stokes:

"Since doctors are subject to all human frailties, it is inevitable that the grievance committee should find among them an occasional badly adjusted and irresponsible personality from whom the public and our own professional repute must be protected."

Utopia for British G.P.'s Now They've More Money?

Now that British G.P.'s have finally won the pay rise they've been seeking for years, will they tend to forget other grievances against the National Health Service?

Almost everybody agrees that Britain's 20,000 family physicians are entitled to the 25-per-cent increase (retroactive to 1948) awarded them by a high court this spring. Even the economy-minded Conservative Government, which had hoped to hold the line on N.H.S. costs, is resigned to the fact that the pay rise will add £45 million to the current budget.

But some observers point out that low pay has been only one of the things troubling G.P.'s in recent years. Other sore spots, such as heavy patient loads and hospital freeze-outs, may eventually cause the Government even more trouble than the problem of paying for the increase.

Rules Confessions Under Hypnosis Are Illegal

Suppose a doctor hypnotizes a patient. Suppose that while hypnotized, the patient confesses to a murder. Can his confession be used lawfully to convict him of murder?

No, it cannot be so used, ruled the New York Court of Appeals recently, in reversing the conviction of a man sentenced to death for killing his parents. And legal experts believe that the decision may be a landmark in medical jurisprudence.

In this case, the "patient" was interviewed by a psychiatrist at the request of the District Attorney. The psychiatrist denied that he used hypnosis. The defendant, however, insisted that the doctor had made various gestures, "first with his hands and then with some object." After that, said the defendant, he recalled nothing. His confession, he protested, was involuntary and untrue.

The Court of Appeals agreed that his confession was involuntary and therefore inadmissible as evidence. It held that "this interview was a subtle intrusion upon the rights of defendant, and was tantamount to a form of mental coercion."

What's more, the court pointed

out that the doctor had violated the defendant's legal safeguards in three ways:

¶ He did not tell the defendant that he had been called into the case by the District Attorney and that the police were listening to their conversation.

¶ He did not tell the defendant that he could have his own doctor or lawyer present.

¶ He did not warn the defendant that he was under no duty to speak and that anything he might say could be used against him.

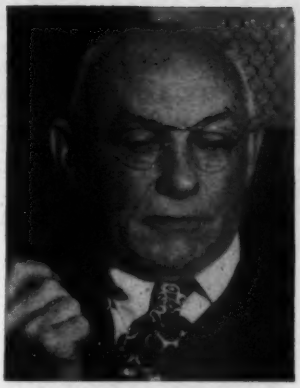
"Aside from constitutional objections," the decision concludes, "we have not reached the stage where medical science . . . establishes the trustworthiness of a confession induced by the means here adopted."

Suggests Medical Schools Admit Fewer 'Brains'

Who's responsible for medicine's current crop of troubles? Dr. Elmer Hess of Erie, Pa., contends that part of the blame should fall on the medical schools.

Generally, says Hess, medical schools are doing a bang-up job. But they're putting too much stress on academic brilliance in picking their students. As a result, "many young men who would make splendid doctors are kept out of medical schools because of mediocre grades."

This is bad, he points out, because the profession is already topheavy with bookworms and super-scientists "who treat diseases instead of human beings . . . Any sap scientist can take out a gall bladder. But only a good doctor knows when an operation is indicated, and how to behave after the patient is sewed up."

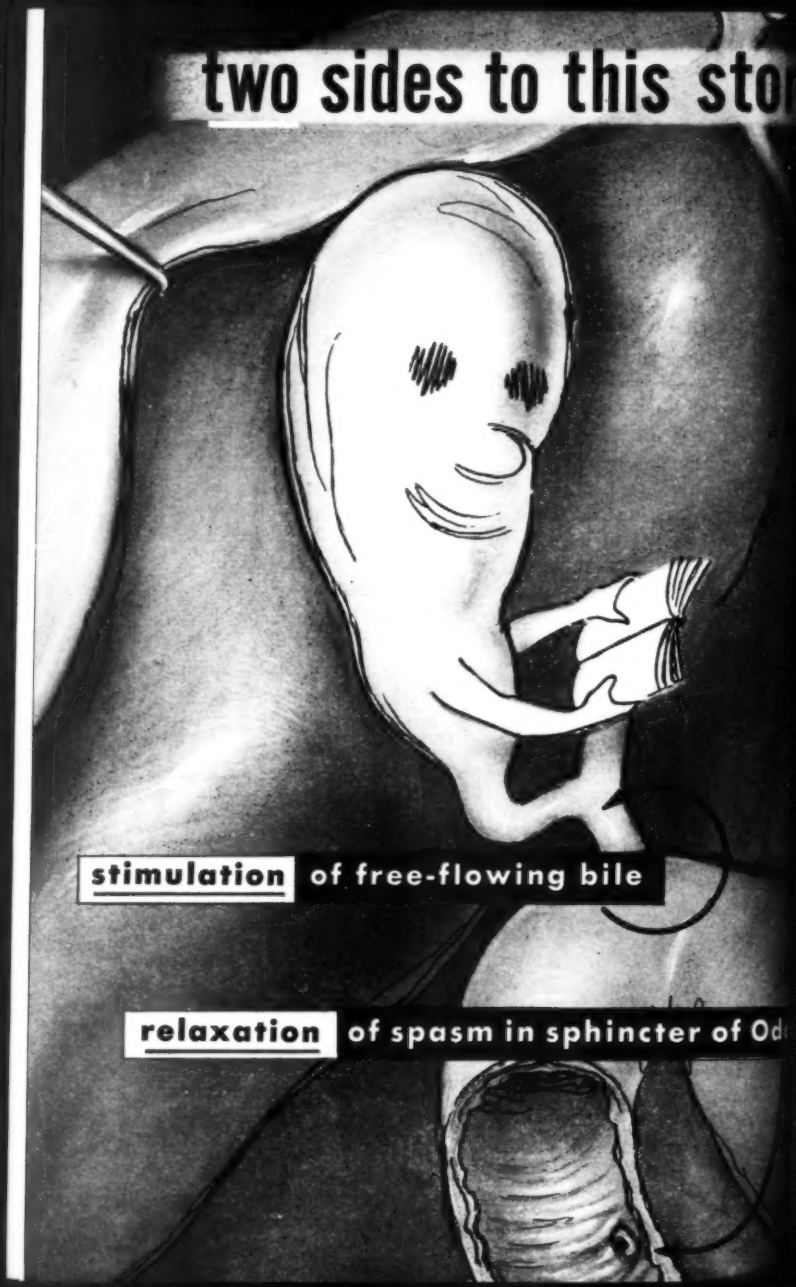


Elmer Hess
Too many 'sap scientists'

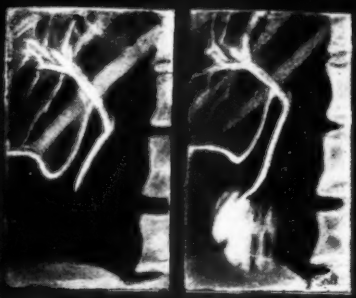
In selecting students, he suggests, medical schools should de-emphasize scholastic standing a bit and put a premium on character. "Without character, medicine is a racket. Take [out] the spiritual values . . . and it can become a terrific racket."

Dead Man's Spirit May Give Town a Doctor

Citizens of Redgranite, Wis., almost gave up hope of getting a doctor in town when Massemino Eannelli was killed. Eannelli, a local lumber man, had been a leader in the movement


two sides to this sto
stimulation of free-flowing bile
relaxation of spasm in sphincter of Od

In many biliary conditions, combined hydrocholeretic and antispasmodic therapy is indicated for best results to flush the bile ducts with a greater volume of bile and to relax spasm in the sphincter of Oddi.



When spasm of the sphincter of Oddi (left) is relaxed (right), bile pours into the duodenum.

Cholan *hmb*

Dehydrocholic acid, the most potent hydrocholeretic known, stimulates copious secretion of thin, free-flowing bile... increases volume output by as much as 190%... is the least toxic of any bile salt, bile acid, or their derivatives.

*Homa*tropine *methyl*bromide and phenobarbital, by their synergistic spasmolytic-sedative actions, relax spasm of the sphincter of Oddi – and neutralize hypertonic dysfunction of the biliary tract.

Cholan-HMB contains, in addition to dehydrocholic acid-Maltbie, 250 mg. (3¾ gr.) per tablet, the spasmolytic *homa*tropine *methyl*bromide 2.5 mg. (1/24 gr.), and phenobarbital 8 mg. (⅛ gr.).

MALTBIE LABORATORIES, INC., Newark 1, N. J.

MALTBIE... *first to develop American process for converting crude viscous ox-bile into chemically pure dehydrocholic acid.*

to get a resident doctor for the little village of 648 people. Now it looks as though—even in death—he will succeed.

For some physician may soon be offered Eannelli's new $27,000 house as an inducement to set up a practice in Redgranite. The lumber man had just finished his dream house—complete with a den finished in aged mahogany—when he set off with his wife and two sons on a trip. At a railroad grade crossing near Michigan City, Ind., tragedy struck. The entire family was killed.

As a memorial to the family, heirs to the estate have offered the new house to the town, with the request that it be used as a combination home and office for a doctor. If the law is willing, Redgranite may soon have its physician—and Massemino Eannelli's wish will have come true.

Newest A.M.A. Activity: Painting 'Camouflage'?

What's the A.M.A. up to now? According to the Committee for the Nation's Health—a leading tub-thumper for compulsory health insurance—the A.M.A. is busy gathering wool to pull over the public's eyes.

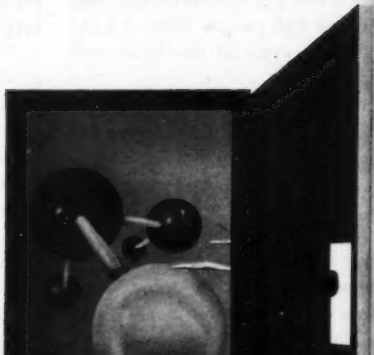
Already, says a recent committee bulletin; "a high-powered, high-priced public relations campaign to explain away sickness costs . . . is being readied by the medical lobby to accompany its 1952 right-wing political campaign." Its purpose: "to lull public concern over doctor and hospital bills."

The committee trains its guns chiefly on the reasoning of A.M.A. research director Frank G. Dickinson. It says Dr. Dickinson resorts to "meaningless average figures" in order to "camouflage high costs of sickness" and to convince Americans that "sickness costs to individuals are low when averaged on a nationwide basis."

Although statistics show that only 4.4 per cent of the money spent by Americans goes for medical care, some families "are forced to spend more than 25 per cent of their incomes" for health, says the committee. Yet, it adds, the A.M.A. implies that "Americans obviously have no trouble paying for medical care because it is only a small part of their family budget—in the same category with entertainment and tobacco."

The trouble with A.M.A. thinking, according to the Committee for the Nation's Health, is that it ignores the fact that "there are few families bearing average medical expenses . . . No family can tell in advance how much sickness it will have or just how much it will cost. No family pays just its exact average share of the total national medical bill . . . A.M.A. reasoning fails to account for the fact that people do not have their choice about medical bills or when they want sickness, as Dr. Dickinson suggests."

The committee seeks to wrap up its argument by quoting the late



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Franklin D. Roosevelt on averages: "A man drowning in ten feet of water gets scant comfort out of knowing that the average depth of the stream is only four feet."

Its conclusion "in a nutshell": "Only complete national health insurance can solve the medical cost problem for all of us."

Are You *Really* Better Off Than in 1939?

You're probably earning a good deal more today than you've ever earned before. But are you really any better off? Or are you actually losing ground, because of higher taxes and inflation?

To find out, check the accompanying chart, prepared by Business Reports, Incorporated, for its bi-monthly "J. K. Lasser Reports on Taxes." It shows how your present income compares in *real value* with your 1939 income. If, for example, your weekly income in 1939 was $150, you should be earning $361.75 a week today just to stay even.

Patrons' Subsidies Called Road to Socialism

A warning that even privately backed medical-care programs may lead patients to accept the concept of socialized medicine has been sounded by a county medical journal.

One such program, says New York Medicine, is being tried out in a Manhattan hospital. Under it, moderate-income patients are offered a complete diagnostic test package for $40—a bargain-basement price possible because the plan is heavily subsidized by a wealthy philanthropist.

Plans like this, the journal concedes, may work out "as long as one

THE REAL VALUE OF YOUR 1952 INCOME

(Based on 1939 Figures)

1939 Weekly Income	Cost of Additional Taxes	Cost of Inflation	1952 Equivalent Income
$ 50	$ 6.75	$ 50.25	$ 107.00
100	21.75	108.00	229.75
150	41.75	170.00	361.75
200	63.50	237.00	500.50
300	161.25	409.00	870.25
500	550.00	887.00	1,937.00

can find wealthy patrons. [But] what happens when these private donations are no more?"

The answer, suggests the journal, is that such subsidized projects create about as many problems as they solve. "To offer . . . medical service at below actual costs is too much like . . . dangling before a donkey a carrot which he can never hope to reach . . . The public is all too apt to see a vision of Utopia that can never be given to all except under a socialistic state and under socialized medicine.

"The plan . . . is certainly a bargain," the journal goes on. "But the patient and the public alike should realize that this 'large economy size' package of medical care comes to them by the altruism of [a patron]."

Says M.D.'s Intimidated Salaried Professors

The resentment that local private practitioners often harbor toward salaried medical school professors who treat private patients is like a volcano. It smolders quietly most of the time, but occasionally it erupts. One recent eruption is described in The Journal of Medical Education.

A full-time professor of a clinical subject had a dispute with medical school authorities over the way he was being paid. He quit. To succeed him as department head, the school named another member of the teaching staff.

The new department head "was subjected . . . to a process of intimidation and petty annoyance . . . Letters and telegrams poured in, vilifying him for accepting the proffered position. Telephone calls of the same type came with such frequency that he had to have his phone disconnected to get a night's sleep." After a few weeks of this, he resigned, too.

An out-of-towner who was about to take the job got the same treatment, plus a threat that he wouldn't be admitted to the local specialty society if he accepted.

Comments The Journal of Medical Education: "It is obvious that the use of such weapons as intimidation and vilification is so far below the accepted ethical standards of a professional group that it will bring to the user only the scorn of his peers. As for the administrator of the medical school, he would be a poor man indeed if he conceded one iota to forces working in such an underhanded manner."

'Any Other Surgery, $5' Say Some Prepay Plans

The patient, a middle-aged woman, suffered a rare complication after treatment for trigeminal neuralgia. As a result, says the Rocky Mountain Medical Journal, she lost most of the right side of her nose, as well as much skin and subcutaneous tissue from her cheek, including the anterior bony wall of the antrum. To restore this loss, the surgeon per-

formed five operations. Yet the woman's insurance company offered her only $35 in all for what it called "this so-called restoration."

In another case, a middle-aged man had an advanced aggressive cancer of the lower lip. His surgeon removed three-fifths of the lip, then reconstructed it with grafts from cheek, chin, and neck. For this successful surgery, the patient's "company insurance" plan was willing to pay a mere $25.

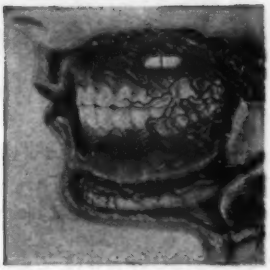
True, the patient had another prepay policy—which offered to settle for $5! The fine print of this contract names two or three standard operations that it covers. Then it adds, "All other operations, five dollars."

In citing these examples of picayune pay-offs by "low-premium, mail-order" prepay plans, the Rocky Mountain journal charges that the payment rates of such companies are based on "antiquated fee schedules which were never fair and equitable even before the advent of Roosevelt and Truman dollars." It sounds a warning: These "lesser companies . . . are exploiting our patients and ourselves as physicians."

With the "well-established, time-tried, and dependable" health plans the journal has no quarrel. But the less ethical companies, it declares, "have no right to put a price on the value of our services. When a fee schedule names a price for a certain operation, the implication is that the surgery is worth that and no more."

The result, according to the journal: "When we accept extraneous

Whenever androgen therapy is required . . .



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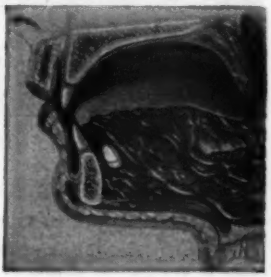


Liver is by-passed as with injection . . .

Metandren Linguets are therapeutically potent because they make possible the absorption of methyltestosterone directly into the systemic circulation. Placed in the buccal pocket or under the tongue, they are absorbed efficiently. Hence the body tissues become permeated with the hormone before hepatic degradation can take place. Metandren Linguets are supplied in strengths of 5 mg. (white) and 10 mg. (yellow) both scored.

Metandren (brand of methyltestosterone)
Linguets (brand of tablets for mucosal absorption)

*ZONDEK, B. P., AND GORDAN, G. S. J. CLIN. ENDOCRINOL. 10:248, 1950.

Ciba

2/1810 M

fixation of our fees without dispute . . . we seem to admit that our normal charges are high . . . [thus] playing into the hands of all insurance carriers"—the good as well as the bad.

And what about the patient who is given "a false sense of security" by such insurance? "If it does not pay his way . . . he is likely to blame the physician and the hospital" rather than the health plan itself.

Therefore, the journal concludes, "It is our obligation to warn our patients and [their] employers [not to spend] good money to procure health and accident coverage which is inadequate, if not fraudulent."

In Coronary Disease It's G.P.'s 2 to 1

That a general practitioner's life is an arduous one goes without saying. But statistical evidence of *how* arduous it is comes from a recent study of coronary disease among British doctors. The study indicates that the disease is twice as prevalent among G.P.'s as among other physicians.

According to the British Medical Journal, the insurance records of several thousand doctors were examined. For general practitioners aged 40-64, the annual incidence of coronary heart disease from 1947 through 1950 stood at 8.8 per thousand; for all other doctors, the incidence was only 4.4.

The study also reveals that one out of every five medical men now under 45 is likely to have a coronary attack before he reaches 65. Never-

theless, the journal observes, there is "very little convincing evidence" that doctors are more subject than other people to the disease.

Prosperous Period? Not For All Physicians

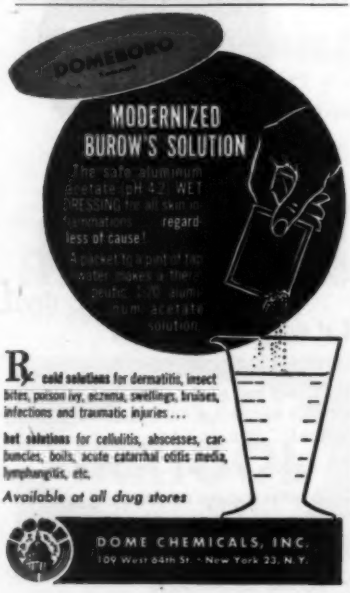
With the talk about physicians' incomes riding at all-time highs, it's easy to forget that even in good times some doctors have bad times.

A gentle reminder comes from Los Angeles County. There, eighty-five doctors or members of doctors' families need a helping hand to get along. The helping hand is provided by the medical society's Physicians Aid Association in the form of cash, reduced hospital and sanitarium rates, clothing, and free medical care. It is extended to aged and disabled physicians, impoverished widows, and children.

The medical society also runs a physicians' home that now houses five doctors and seven doctors' wives. To pay for its aid program, the society conducts two fund-raising drives a year, climaxing them with raffles of cars, fur capes, and the like.

Raps Specialists' Failure To Make Night Calls

Are some doctors shirking their responsibility by refusing to make night calls? Charging that they are, the Hudson County (N.J.) Medical Society bulletin points to an "increasing" number of complaints from patients. As a consequence, it



says, "the public is fast losing its respect for M.D.'s in general."

In particular, the bulletin aims a broadside at those specialists who claim a right to be spared "unwanted" night calls: "We would remind them that they are doctors first and specialists solely by choice. They might further note that the patients they refuse to make night calls upon are the same families which pay their specialist fees and compose their specialty practice. Personally, we are a bit fed up with such prima donna antics and would remind these men that the general practitioner to whom they so glibly refer these night calls is frequently far from impressed as to the need for so many specialists and acutely aware that many of them have built their practices upon the questionable tactics of the well-known hospital staff 'freeze-outs.'"

Is One-Disease Research A Dog-Wagging Tail?

"The single-disease foundation has proved effective as a money-raising device." Unfortunately, though, it has sometimes seemed to act in "the capacity of a tail to wag a dog."

In support of this thesis, the New England Journal of Medicine cites a national trend toward single-disease research, which, it claims, is "profoundly shortsighted." What's needed, says the journal, is more emphasis on "broadly integrated investigation and concerted applications of the scientific method to whole areas of knowledge"—the type of research

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that has been "largely responsible for the accelerated progress of medical and physical sciences since the end of the first World War."

The success of the Manhattan Project has demonstrated the value of broad-front methodology in the field of physics, the journal points out. It hopes to see comparable progress in medicine: "There is no reason [why] the investigator interested in poliomyelitis should not be interested in cancer or the common cold."

Pharmacists Charge M.D.'s With Drug Violations

Office-dispensing M.D.'s are used to having an accusing finger pointed at them by pharmacists. Thus many Wisconsin physicians are probably not surprised at once more becoming the target of some legal action. In a suit against the state board of pharmacy (which issues licenses to M.D.'s.), the Wisconsin Pharmaceutical Association has asked the court to stop doctors' aides from dispensing drugs.

Some Wisconsin physicians, the pharmacists charge, are giving too much leeway to their "office girls" in this matter, and in so doing are violating the state's dangerous drug act, which prohibits the handling of certain drugs by unqualified persons. The pharmaceutical association claims it has evidence that such violations are widespread. Moreover, it adds, many doctors sell drugs at a profit, in violation of medicine's code of ethics.

Speaking for the medical men,

REFERENCES:
1. Robinson, F. H., Jr., and Farr, L. E., Ann. Int. Med., 14: 42 (1940)
2. Bickers, W. and Woods, M., Texas Rep. Biol. Med., 9: 406 (1951)
3. Voinder, M., Indust. Med. Surg., 20: 190 (1951)
4. Bickers, W. and Woods, M., New England J. Med. 245: 453 (1951)

Charles L. Crownhart, executive secretary of the Wisconsin state medical society, has denied the accusations. The amount of drugs dispensed in doctor's offices, says Crownhart, is "insignificant compared with the total." Most office dispensing by doctors, he points out, is done in rural communities, often during hours when pharmacies are closed.

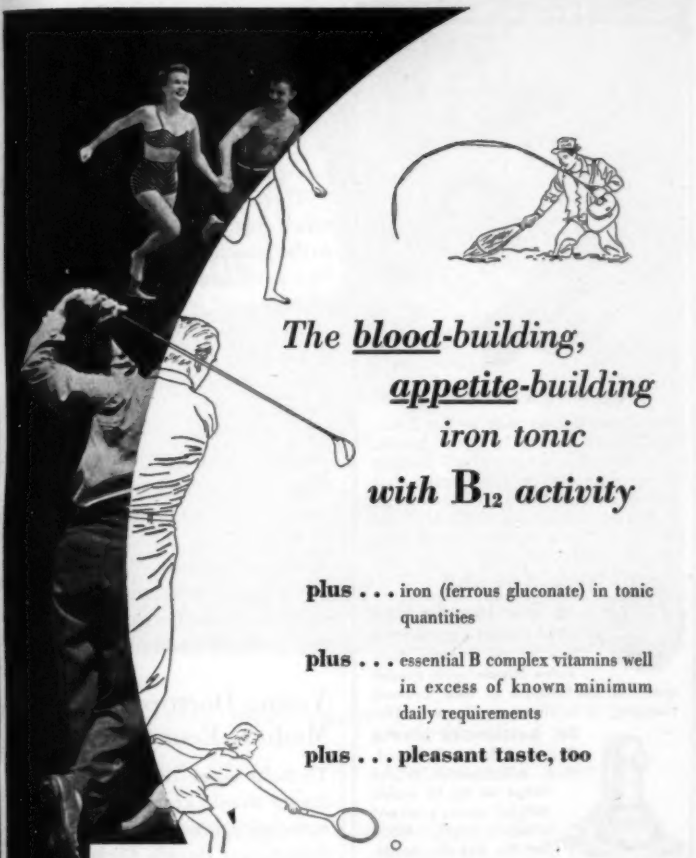
As for the ethics of office-dispensing, Crownhart has explained that the A.M.A. code never meant that doctors should sell drugs at a loss. Whatever little a doctor charges in excess of the cost-price of the drug, he says, is to cover the costs of dispensing it.

A little more than a year ago, Wisconsin's pharmacists made similar charges against M.D.'s. But when the state Attorney General ruled that a doctor's assistants may dispense drugs under the doctor's orders, the board of pharmacy took no action on the complaints.

Service Principle Called Vital to Prepay Plans

The service principle (as opposed to the indemnity concept) is the earmark of any prepaid health plan that the medical profession can afford to sponsor, according to James E. Bryan, administrator of the Medical-Surgical Plan of New Jersey.

Cash indemnity insurance, says Bryan, was offered years before Blue Shield came on the scene. But families in the lower income groups simply didn't have enough cash on hand



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to meet the cost of major illnesses they wanted assured medical treatment, not delayed indemnities. Accordingly, when health insurance on an indemnity basis was made available, there was "little or no acceptance among lower income families."

There are, Bryan points out, two other excellent reasons for adhering to the principle of "benefits provided by a participating physician in terms of fully paid services":

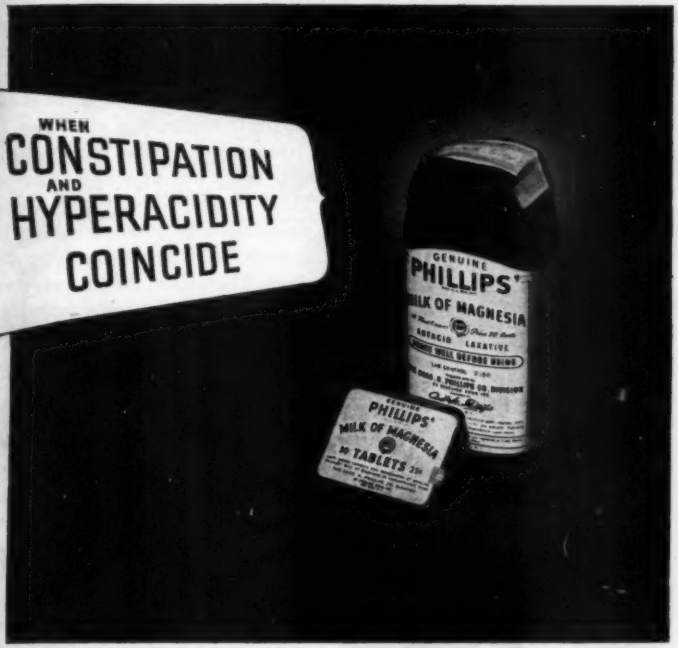
1. The service plan does not involve medical men "in direct competition with the commercial insurance companies."

2. It is "the one type of prepayment plan that enables every physician to participate, concretely and consciously, in solving a great social problem. It is the only plan that builds a tangible solidarity among physicians in demonstrating the ability of the profession to meet its basic responsibility to the public."

Young Doctors Learn Medical Economics

To help learn "what every young doctor should know" about medical economics, internes and residents at three Grand Rapids, Mich., hospitals have a full-dress course expressly designed for them—thanks to the enterprise of a local layman.

Now in its third year, the "Grand Rapids Plan" offers an annual series of seventeen formal lectures. Each lecture is followed by a question-and-answer period. These one-hour sessions are presented twice a month at each hospital from October to



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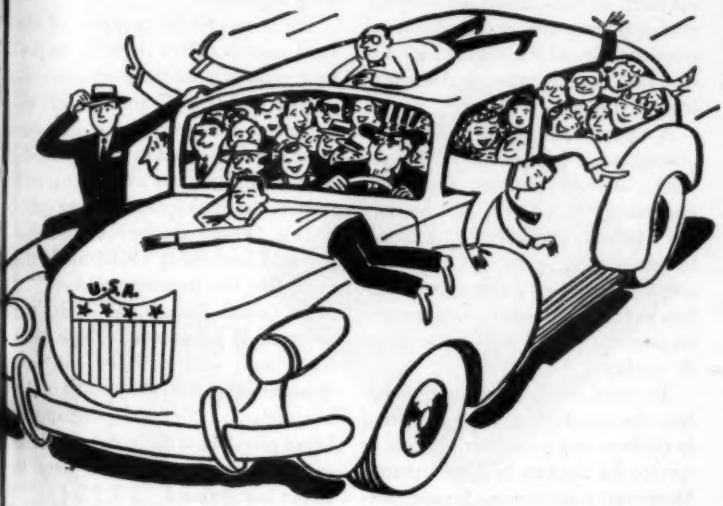
June. The classes are free and the hospital staff attends them voluntarily. Yet despite the press of hospital duties, attendance has averaged 70 per cent of all internes and residents available at class time.

Instruction begins with a discussion of the initial problems that are likely to confront a young doctor: choosing a location, financing his practice, and purchasing his equipment. Thereafter, the subjects cover the full range of medical economics —including fee setting, insurance, malpractice, ethics, and public relations.

To teach these subjects as part of the local hospitals' interne-resident educational programs was an idea that originated with a Grand Rapids insurance man, E. C. Woodburne. Mr. Woodburne, who specializes in life insurance and estate planning for doctors, had got the inspiration from his clients. Why, they asked him, can't young doctors be better prepared for the facts of practical medical life?

The question took hold, and eventually Woodburne hit upon his answer to it. He took his proposal to local medical society and hospital officials and got their full approval. The profession, however, does not actually sponsor the program. On Woodburne falls the responsibility of setting up the course, getting speakers, and conducting the classes.

For his instructors, Woodburne draws heavily on local talent, but he also enlists authorities from other parts of the state. Thus, prominent local physicians or state medical so-



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By stimulating the sale of the new and the resale of the old, our competitive system achieves widespread ownership of automobiles, as with almost everything else. In most foreign countries, out of necessity people make things last as long as possible. In the U. S. A., vigorous competition prompts continuous progress. Buyers of new cars get maximum value, because each manufacturer competes actively for the new-car dollar. Lowest-income groups benefit by the lowered prices of used, yet essentially useful, products. Overall result: The world's highest standard of living. In most of the rest of the world, only the rich enjoy luxuries. In the U. S. A., the irresistible drive of competition places most of the miraculous products of modern living within reach of all.

Free competition—like freedom of speech, press and religion—is a dynamic part of Uncle Sam's character. Let's keep it free, so that the U. S. A. continues to be the greatest country in the world.

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ciety representatives handle such subjects as fees, referrals, hospital staff appointments, and professional relations. Grand Rapids lawyers discuss malpractice, taxes, and medicolegal testimony.

A representative of a professional management firm in Battle Creek, Mich., advises on types of practice and choice of location and teaches the ABC's of bookkeeping. A hospital purchasing agent and an equipment salesman give the young doctors pointers on how to save money on new equipment and how to judge its quality.

To avoid any hint of commercialism, the speakers are not permitted to endorse any particular product or service for doctors in their lectures. Moreover, none of them is paid; out-of-towners even pay their own traveling expenses.

For a successful program of this kind, such a policy is vitally important, reports a physician closely connected with the Grand Rapids experiment. Lecturers, he points out, must be able, reputable individuals who "can command attention and respect from skeptical young physicians. Otherwise, the feeling of being sold something undermines the good that can be accomplished."

In Grand Rapids, he adds, the program is a success. "These talks have been well attended and well thought of by the house staffs of the hospitals . . . National programs to bring physicians up to date in these matters are fine, but the place to begin is at home."

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MERLE L. YOUNGS, PRESIDENT

Memo from the Publisher

● A local physician blew into our editorial offices some time ago under a fine head of steam. "What do you mean," he demanded of our awe-struck receptionist, "by printing articles that favor things like socialized medicine and osteopathy? And how about these articles criticizing A.M.A. policies, sometimes even individual physicians? Whose side are you on, anyway?"

It's just possible that our receptionist, whom we didn't hire for her agility in public debate, was unable to cope with the situation. We have a hunch that our irate visitor, who wouldn't stay to talk with anyone else, got away with his safety valve still untripped. If so, we consider it one of the most-missed opportunities of the season; for there's no question—in our own minds, at least—about what our editorial policy is:

MEDICAL ECONOMICS is against state medicine. It is against unqualified practitioners. It is for organized medicine. It is for the individual physician.

So far, no surprises.

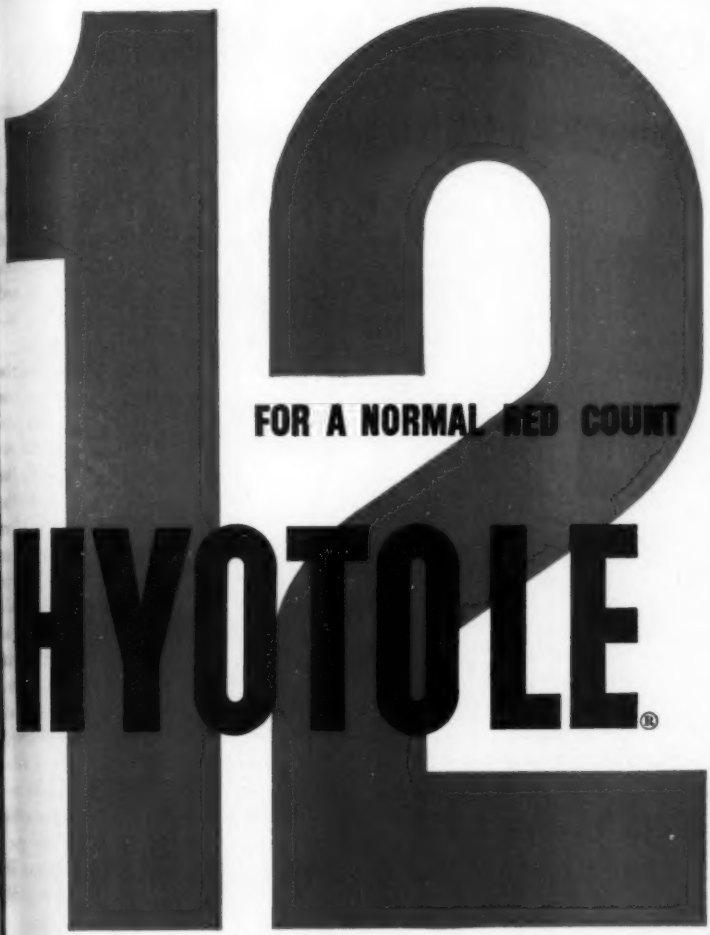
It does occasionally surprise some doctors, however, to learn that MEDICAL ECONOMICS is independently owned and published. Specifically, that means its editorial policy is independent of both its advertisers and the A.M.A. No publication worth its salt would fail to take advantage of that position by (1) reporting both sides of controversial questions, and (2) seizing every chance for unbiased appraisal and evaluation.

This vantage point seems all the more worth protecting when one thinks about the other medical periodicals. The Journal A.M.A., for example, could scarcely print with the same freedom both the good and the bad about A.M.A. actions. Other official medical society publications are similarly limited in what they can say. Nor could a pharmaceutical-house publication be expected to talk bluntly about imperfections in the present system of medical care.

The way we look at it, MEDICAL ECONOMICS' job is to help doctors both individually and collectively. And helping them isn't usually accomplished by tossing bouquets. It's accomplished more often by presenting straight facts; by airing all shades of opinion about them; and by stating objective conclusions.

We've said these things before. But since they're basic to an understanding of MEDICAL ECONOMICS and its methods, it's perhaps a good thing to restate them from time to time. .

—LANSING CHAPMAN



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